

Medication Aide Program Checklist

- Form 5538-MA: Understanding of Required Background Check
- Form 5537-MA: Request for Criminal History Evaluation Letter for Medication Aide Permit. *(This is to be completed if there is anything that comes back on your background check)*
- Form 5534: General Statement Enrollment
- Current Shot Records as required by the Department of State Health Services at the time of enrollment MMR (2); Tetanus (<10 years); Varicella (2); and Hepatitis B Series (2 of 3 doses – must be completed)
- Certified copy of high school diploma/transcript or high school equivalency; or certified transcript from college or university with credit classes.
- Fingerprints must be submitted through the Department of Public Safety's vendor. To obtain the required service code, email: medication_aide_program@hhs.texas.gov
 - YOU MUST SEND AN E-MAIL TO THE ABOVE E-MAIL ADDRESS TO GET A CODE FROM THE STATE TO SET UP AN APPOINTMENT WITH IDENTIGO TO COMPLETE YOUR FINGERPRINTS. The code must be requested by the first week of class and then you must schedule an appointment with IDENTIGO by following the steps from Health and Human Services.**
Once the fingerprint process has been completed it can take up to 10 business days for the results to be processed.
- IDENTIGO is housed at High Caliber Gun Range located at:
7475 Central Freeway N, Wichita Falls, TX 76305**

Please note, there will be an additional fee that will need to be sent to the State of Texas after you have been approved to register for the Medication Aide program.

All of these requirements must be completed to be approved to register for the Vernon College Medication Aide Program. If any of these items are not returned and/or completed, you will not be approved to take the course. Upon acceptance of the Medication Aide program, you will receive your original documents back and Continuing Education will keep a copy. You will meet with the Coordinator of CE Allied Health to create a TULIP account and upload the required documents to the State of Texas's registry system.

Packet DUE by 12:00PM August 9, 2024

Registration & Payment DUE by 6:00 PM on August 20, 2024



Medication Aide Program
Medication Aide Experience Documentation Report

1. Applicant Name (last, first, middle initial)		2. Social Security No.	
3. Applicant Job Title			
4. Place of Employment			
5. Address (Street or P.O. Box)		6. City	7. State
			8. ZIP Code
9. Phone Number (Including Area Code)			
10. Type of Facility	11. Applicant Job Title	12. Nurse Aide Certification No. (if Applicable)	13. Type of Work Performed
14. Facility Administrator/Program Director/DON			

I, _____ (Facility Administrator/Program Director/DON), certify that I have employed _____ (Applicant) from _____ to _____

and that I know of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide, or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

On this _____ day of _____, 20____, in _____

I certify under penalty of perjury that the information submitted is true and correct.

Signature --- Facility Administrator/Program Director/DON

Facility Vendor No.

The State of _____
County of _____

Before me, a notary public in _____ County, Texas on this day personally appeared

(Facility Administrator/Program Director/DON)
whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand seal of office, this _____ day of _____, 20____

Signature --- Notary

Place Notary Seal
or Stamp Here

Printed Name --- Notary

Commission Expiration Date



Medication Aide Program
General Statement of Enrollment

All required forms must be completed and returned in the applicant's TULIP account **no later than 20 days** after the date of the first scheduled class where you are enrolled.

The application cannot be processed if any portion of the form is incomplete, fee is not included or documentation is missing.

Section 1 – Medication Aide completes this application.

Read the following instructions before completing.

- Complete all information in Section 1 and sign to verify the information provided is correct.
- Applicant must sign and date in front of a notary.
- Form must be submitted to your TULIP account by creating the Initial Medication Aide application at [Texas Unified Licensure Information Portal](#).

1. Name (Last, First, MI)	2. Social Security No.		
3. Email Address	4. Home Area Code and Phone No.		
5. Mailing Address (Street or P.O. Box)	City	State	ZIP Code
6. Date of Birth (mm/dd/yyyy)	7. Name of Approved Training School		
8. Mailing Address of Approved Training School (Street or P.O. Box)	City	State	ZIP Code

9. Submit Form 5523, Medication Aide Experience Documentation Report. It documents 90 days of employment in an assisted living facility licensed under Health and Safety Code 247, state supported living center or Intermediate Care Facility for Individuals with and Intellectual Disability as unlicensed direct care staff. This employment must be completed within the 12-month period before the first official class date. **An applicant employed as a certified nurse aide is exempt from the 90-day requirement.**

10. Submit a notarized photocopy as a true copy of an unaltered original of a high school graduation diploma or transcript or a general equivalency diploma. A foreign education evaluation agency must evaluate all foreign education diplomas.

11. All applicants must request a fingerprint-based criminal history check from the Texas Department of Public Safety (DPS) before HHSC can approve your application for examination. Visit [Texas Department of Public Safety \(DPS\)](#) for instructions on how a person can get a fingerprint based criminal history check, or call Fingerprint Applicant Services of Texas (FAST) at 888-467-2080. To get the service code, email the [Medication Aide Program](#). Failure to complete a fingerprint criminal history check will delay the process and may result in denial.

12. Date of First Scheduled Class of Instruction (mm/dd/yyyy): _____

13. Are you able to read, write, speak and understand English? Yes No

14. Are you at least 18 years old? Yes No

15. Are you, to the best of your knowledge, free of contagious diseases and in suitable physical and emotional health to safely administer medications? Yes No

16. Are you listed on the Employee Misconduct Registry (EMR) as unemployable? Yes No

17. Have you been convicted of a criminal offence listed in Texas Health and Safety Code Section 250.006? Yes No
If yes, list date _____ and conviction _____

18. Have you received a copy of the Medication Aide Training Program Rules? Yes No
If no, get a copy from the training program or call this office.

With few exceptions, you have the right to request and be informed about the information that THHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask THHSC to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004) To find out about your information and your right to request correction, please contact this office.

Read Carefully

When applying to the HHSC Medication Aide Program for a permit as a Medication Aide, I have read and agree to abide by the Medication Aide Training Program rules. I also agree to complete all application requirements and take all examinations necessary to process my application. When a permit is issued, I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (TAC 557.105). I further understand the materials submitted for consideration become department property and are nonreturnable. I am aware of the schedule of fees in TAC 557.109(c) and understand that additional fees must be paid to keep the permit current.

I further agree that if issued a permit, upon the denial, suspension, or revocation of that permit, I shall return the permit to the department. The information I have provided in this application is truthful. I understand that to falsify any information submitted to HHSC may result in voiding this application, failure to be granted a permit or the revocation of my permit.

Signature of Applicant _____ Date _____

Section 2 – Notary Signature

Notary completes this section. Notarize applicant signature at the bottom of this section and return to applicant.

The State of _____
County of _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledged that he or she had executed the same for the purposes and consideration therein expressed and the foregoing statements are true and correct.

Given under my hand seal of office, this ____ day of _____, 20 ____

Notary Public in and for _____ County, Texas or _____

Signature — Notary

Place Notary Seal
or Stamp Here

Printed Name — Notary

Commission Expiration Date

Submit by mail:
Medication Aide Program
P. O. Box 149030
Mail Code E-416 Austin, TX 78714-9030

With a few exceptions, you have the right to request and be informed about the information that HHSC gets about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, contact the Long-Term Care Regulatory Medication Aide Program at 512-438-2025.



Request for Criminal History Evaluation Letter for Medication Aide Permit

Complete this form if you are requesting Texas Health and Human Services Commission (HHSC) to issue a criminal history evaluation letter regarding your eligibility for permitted medication aide.

I, _____ will enroll, or am enrolled, in an educational program in preparation for, or plan to take, the examination for an initial:

Certified Medication Aide (CMA) Permit

I understand that I may be ineligible for a permit because of my conviction or deferred adjudication for the following felony or misdemeanor offenses:

All items marked with an asterisk (*) are required. Incomplete applications will not be processed.

*Name (Last, First, Middle)	Maiden Name	Other Surnames	Sex
*Street Address	*City	*State	*ZIP Code
*Date of Birth (mm/dd/yyyy)	*Social Security No.	Area Code and Phone No.	
*Email Address			

I request a criminal history evaluation letter determining whether I am eligible for a permit based on the fingerprint-based criminal history check results I must provide to HHSC. I understand that the evaluation letter may not address issues I do not disclose on this request, issues that were not reasonably available to HHSC at the time of my request, and eligibility requirements unrelated to criminal history.

I understand I must request the fingerprint-based criminal history check at <https://uenroll.identogo.com> to obtain the service code for the check.

Contact the Criminal Background Check program at: LTCR_Criminal_Background_Checks@hhs.texas.gov.

*Signature

*Date

Allow two weeks for processing.

Submit by email at LTCR_Criminal_Background_Checks@hhs.texas.gov.

Understanding of Required Criminal Background Check

I _____, prospective Medication Aide student, understand that I am required to complete and pay for a Texas Department of Public Safety (DPS) fingerprint criminal background check to determine my eligibility to take the Medication Aide examination.

I also understand that I may request a Criminal Background Check Evaluation Letter from Texas Health and Human Services Commission (HHSC) prior to enrolling in a training program to determine if I am eligible for a permit. I understand that the Evaluation Letter will not address all exam eligibility requirements and is not a guaranty of eligibility.

In addition, I understand I must request the criminal background check through DPS at https://www.dps.texas.gov/administration/crime_records/pages/FASTSubLoc.htm.

Signature of Prospective Medication Aide Student

Date

Training Program Name: _____