State of Idaho
Division Of Occupational and Professional Licenses
Board of Nursing

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 332-3433
dopl.idaho.gov

INITIAL APPLICATION & RENEWAL - CERTIFIED MEDICATION ASSISTANT (MA-C) CHECKLIST

	INITIAL - Completed Application with Non-Refundable Application Fee - $100 *or RENEWAL - Completed Application with Non-Refundable Renewal Fee - $35 Mail To: 11341 W. Chinden Blvd. Building #4, Boise, ID 83714
	INITIAL & RENEWAL - Proof of Registration Proof of nursing assistant registry currently maintained by the Idaho Department of Health and Welfare, if registered as a nursing assistant prior to July 1, 2020.
	INITIAL - Proof of Medication Aide Certification Exam If not registered as a nursing assistant prior to July 1, 2020: Proof of (a) passing the medication aide certification exam approved by the national council of state boards of nursing or (b) another exam for medication aides from a nationally or regionally recognized nursing testing organization.

FEES ARE NOT REFUNDABLE. Please make checks and money orders payable to DOPL. All returned checks are subject to a $20.00 fee and the application will be invalid.

ATTENTION MEMBERS AND SPOUSES OF MEMBERS OF THE ARMED SERVICES
If you are a member of the armed forces, an honorably discharged veteran or the spouse of an active member or veteran of the military, you are entitled to certain benefits because of your service. Those benefits include expedited processing of your application.

I hereby submit the following information and make application to in the State of Idaho under the provisions of Idaho Code 54-1406A and provide the following:

1. **Full Name** _____

2. **Phone** (____)_____ Other (____)_____
(The above phone number is a public record.)

3. **E-mail** _____

4. **Address of Record** _____
(The above address is a public record.)

5. **Social Security No.** ____/_____/_____
(This is not a public record; required by I.C. § 73-122.)
Processing will be delayed for applications that do not include a social security number or other documentation required under Idaho Code § 73-122.

6. **Date of Birth** _____/_____/_____
mm dd yyyy

7. **Is the applicant or their spouse an active member or honorably discharged veteran of the United States Armed Services? ( ) Yes ( ) No**

8. **Name of Medication Assistant – Certified Program** _____

9. **Location of Program** _____ **Dates Attended** _____

10. **Program length was at a minimum 60 Hours didactic and 40 Hours clinical. ( ) Yes ( ) No**

SCREENING QUESTIONS		
If you answer "Yes" to any of the questions below, please attach a complete explanation including dates, circumstances, and supporting documents.	YES	NO
Have you ever had substantiated charges through the Nurse Aide Registry?		
Have you ever had an application for medication assistant – certified denied?		
Do you have, or have you been diagnosed as having, or have you been treated for having a physical or mental condition, including drug or alcohol misuse during the past five (5) years, which may impair your ability to practice with reasonable skill and safety?		
Do you currently have any felony or misdemeanor charges pending against you in any jurisdiction?		
Have you ever been convicted of a misdemeanor or felony in any jurisdiction?		

DECLARATION

I _____, certify that I am the person described and identified in this application. I certify that I am the lawful recipient of the education which satisfies the requirements of Idaho Code Section 54-1406A and was procured in the regular course of instruction without fraud or misrepresentation.

I further certify that I have read the statutes pertaining to Certified Medication Assistants under Idaho Code Section 54-1406A. If a certificate of medication assistance is issued to me, I understand that any violation of laws or rules may result in disciplinary action. Should I furnish any false information or cause any material omission in this application, such act constitutes good cause for denial, suspension, or revocation of my certificate.

I understand that the Board of Nursing and the Division of Occupational and Professional Licenses retains the right to promulgate rules or legislation which may impact the validity of my certificate.

I certify (or declare) under the penalty of perjury pursuant to the law of the State of Idaho that the foregoing is true and correct.

Signature of Applicant _____Date _____

FOR OFFICE USE ONLY

Processed By: _____Application Rcvd. : _____

Application Approved: _____ MA-C No: _____