Oklahoma State Department of Health
Nurse Aide Registry
P.O. Box 268816
Oklahoma City, OK 73126-8816
Telephone: (405) 426-8150

Application for Training Program for Certified Medication Aides - Diabetes Care

Check the type of training program you will be providing.

☐ Glucose Monitoring (does not require written exam)

☐ Glucose Monitoring and Insulin Administration (requires written exam)

Complete the following and return to the above address
Please type or print information

Organization/Agency Name: _____

Address: _____

Telephone Number: _____Fax Number:_____

Contact Person/Title: _____E-mail Address:_____

The program must submit the following information as specified in OAC 310:677-13-9 (b) with a $100.00 non-refundable application fee:

Instructor names and qualifications:

Attachment #1
Complete the attached Certified Medication Instructor Qualifications Application as specified in OAC 310:677-13-3.

Classroom and Clinical facilities:

Attachment #2
Complete the attached Name and Location of Classroom and Clinical Facilities as specified in OAC 310:677-13-9.

Program outline, with objectives, curriculum and instruction methods

Complete a program outline, with objectives, curriculum and instruction methods as specified in OAC 310:677-13-4. (**Attachment #3** is the current rules as specified in OAC 310:677-13-4 (c).)

Attachment #4
Complete a Knowledge Proficiency Checklist to demonstrate the program addresses functions as specified in OAC 310:677-13-7. (Attached is an approved model Knowledge Proficiency Checklist that you may use or submit another checklist for approval.)

Attachment #5
Complete a Blood Glucose Monitoring Clinical Skills Proficiency Checklist to demonstrate that the program addresses skills as specified in OAC 310:677-13-7. (Attached is an approved model Blood Glucose Monitoring Clinical Skills Proficiency Checklist that you may use or submit another checklist for approval.)

Attachment #6
Complete an Insulin Preparation and Administration Clinical Skills Proficiency Checklist to demonstrate that the program addresses skills as specified in OAC 310:677-13-7. (Attached is an approved model Insulin Preparation and Administration Clinical Skills Proficiency Checklist that you may use or submit another checklist for approval.)

Competency Evaluation:

Clinical examination will be administered at:

Name of Facility/Entity:_____

Physical Address of Facility/Entity:_____
Address State Zip

Facility/Entity Contact Person:_____ Telephone Number:_____

Attachment #7
Complete a Blood Glucose Monitoring Clinical Examination documenting the return demonstration of skills as specified in OAC 310:677-13-4 (c) (3). (Attached is an approved model Blood Glucose Monitoring Clinical Examination that you may use or submit another checklist for approval.)

Attachment #8
Complete an Insulin Preparation Clinical Examination documenting the return demonstration of skills as specified in OAC 310:677-13-4 (c) (3). (Attached is an approved model Insulin Preparation Clinical Examination that you may use or submit another checklist for approval.)

Attachment #9
Complete an Insulin Administration Clinical Examination documenting the return demonstration of skills as specified in OAC 310:677-13-4 (c) (3). (Attached is an approved model Insulin Administration Clinical Examination that you may use or submit another checklist for approval.)

Attachment #10
Complete a Mixing Insulin Clinical Examination documenting the return demonstration of skills as specified in OAC 310:677-13-4 (c) (3). (Attached is an approved model Mixing Insulin Clinical Examination that you may use or submit another checklist for approval.)

Written examination will be administered at:

Name of Facility/Entity:_____

Physical Address of Facility/Entity:_____
Address State Zip

Facility/Entity Contact Person:_____ Telephone Number:_____

I certify that the foregoing is true and complete to the best of my knowledge.

_____
Type or Print Name of Authorized Individual Signing for Entity

_____ _____
Signature Date