# Certified Medication Aide Application Packet

**Application packet is due 10 days before the first day of class.**

**Cisco College**
**Certified Medication Aide**

- **Students MUST complete the Cisco College Application**
    1. **Go to www.cisco.edu**
    2. **Select ADMISSIONS**
    3. **Complete the online application.**

- **Complete application packet. Application is DUE 10 days before the first day of class.**

- **Cost: $1,300.00**
    - **MUST be paid in full when turning application in.**
    - **Student is also responsible for cost of:**
        - **10 panel drug screen**
        - **Forms that are to be notarized**
        - **Any immunization fees**
        - **$25.00 non-refundable fee (cashier's check or money order) to process a background check.**

- **Textbook IS included in cost of the program, and will be distributed on the first class day.**

- **Certification Exam: (Please check requirement information and specific instructions or this with your instructor)**
    - **Due when setting up exam date; the student is responsible for setting up exam date.**

- **Return applications and required documents to:**
  **Cisco College Team Workforce**
  Dr. Kam Zinsser, Dean of Workforce & Economic Development
  Mychellya Shadle, Coordinator of Workforce & Economic Development
  **Cisco-Abilene Campus**
  **717 East Industrial Blvd.**
  **Abilene, Texas 79602**
  ***no incomplete packets will be taken.**

**Cisco College**
**Certified Medication Aide**

**The Certified Medication Aide (CMA) program is a 130-hour course. The class will last between 3-5 months. The class includes 10 hours of clinical experience, including clinical observation and skills demonstration under the direct supervision of a licensed nurse in a facility, and 10 hours in a return skills demonstration laboratory. This is a licensure program, meaning that your training ends with you taking and passing a state exam which qualifies you for licensure. You must first apply and be accepted into the CMA program before being allowed to register. Please review your CMA application packet in the detail to become familiar with the application requirements. Keep in mind Cisco College enrolls a maximum of 15 students per class.**

**Requirements**

- **You must meet specific employment criteria to qualify for the Medication Aide Program. You must be employed as a Certified Nurse Aide in a licensed long-term care facility on the first official start date of the training program, OR**
  **You must be employed as a non-licensed direct care staff in a licensed personal home, state school, assisted living facility, Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/MR), or correctional facility**
- **You must have been employed in this capacity for at least 90 days**
- **It is the student's responsibility to ensure that their employment facility agrees to allow the student to perform the 10-hour clinical training.**
- **If your employment changes while you are enrolled in the program, you must obtain a new position that meets one of the above requirements.**
- **You do NOT qualify for a CMA program if you are employed in a hospital, home health agency, or staffing agency.**
- **Be at least 18 years of age**
- **Read, write, and understand English**
- **Submit proof of high school diploma or GED**
- **Satisfactory Criminal Background Check (Cisco is responsible for processing)**
- **10 panel with itemized negative result drug screen required prior to application being processed**
- **Go to: Any Lab Test Now**
  **3351 Turner Plaza Drive, Suite 108**
  **Abilene, Texas 79606**
  **Hours: 9am-5pm**
  **(325)691-7256**
  ***Have the lab fax the results to: Cisco College Attn: Kam Zinsser (254)442-5100**

- **Valid Driver's License and signed Social Security Card need to be provided**
- **Provide proof of the following immunizations:**
  - **Hepatitis B (3 series; takes up to 6 months to complete)**
  - **Tetanus/Diphtheria/Pertussis (TDap; within the last 10 years)**
  - **Mumps/Measles/Rubella (MMR; 2 series)**

- **Varicella (2 doses; or proof that you have had the chicken pox)**
- **Negative Tuberculosis Skin Test (within the last 12 months)**
- **Annual Flu Vaccine**
- **Meningococcal (all students under the age of 22 years of age; within the last 5 years)**
  **Note: some immunizations can take up to 6 months to complete, so please plan ahead.**

- **Students must be free of communicable diseases**

# Cisco College
# Certified Medication Aide
# Course Schedule

**Start Date: TBA**

**New Classes will start approximately every 14 weeks.**

## Class Days and Times

**This program runs for 12 weeks and includes 130 hours of classroom, lab, and practicum in an approved facility. Classes are held Monday, Tuesday, and Thursday evenings on the Cisco Abilene Campus.**

- **100 hours of classroom instruction and training**
- **20 hours of returned skills demonstration laboratory**
- **10 hours of clinical experience, including clinical observation and skills demonstration under the direct supervision of a licensed nurse in a facility, and 10 hours in a return skills demonstration laboratory.**

***This schedule is subject to change due to lack of participation or other unforeseen circumstances.**

# Cisco College
# CNA Refund Policy & Absence Policy

- **Once payment is received, there will be no FULL refund.**

- **NO refund will be given on or after the first day of class.**
- **A FULL refund will only be given if the college must cancel the class.**

  - **Withdraw request must come directly from the student or his/her designee. A withdraw request form will be completed by the person making the request. The official receipt date is the day and time the request is received. All refunds are paid by check to the student regardless of the method or source of original registration payment. Please allow 4-6 weeks for the refund check to be processed and mailed to the address given at the time of registration. If there has been an address change, please provide the correct address with the withdraw request.**

- **Absence Policy: A student that misses 8 or more hours of class will be dropped from the program with no refund.**

# CMA Registration Form

717 East Industrial Blvd
Abilene, Texas 79602
(325) 794-4590
Please return to: Cisco College Team Workforce

## Certified Medication Aide
## Cisco-Abilene Campus

| Last Name: | First Name: | Middle Initial: | Preferred Name: | |
|---|---|---|---|---|
| Mailing Address: | City: | State: | Zip: | County: |
| Contact Number: | Email: | | | |
| Social Security Number: | Driver's License Number & State: | Gender | Birthday: | |
| Citizenship:<br>○ United States<br>○ Other<br>__________ | Ethnic Origin:<br>○ Caucasian/White<br>○ African American<br>○ Hispanic<br>○ Asian<br>○ American Indian/Alaskan Native<br>○ Other | | | |

**Emergency Contact:**

Name:_______________________________________ Relationship:_____________________________________

Phone:__________________________ Address:_______________________________________________________

**NOTICE: If you had the Varicella vaccine, you DO NOT need to complete this form.**

# Cisco College

## DOCUMENTING HISTORY OF ILLNESS: VARICELLA (CHICKENPOX)

### Amendment to ™ 97.67

***A written statement from a physician or the child/student's parent or guardian must support all histories of Varicella illness. The statement must contain wording such as: "This is to verify that (name of student) had Varicella disease (chicken pox) on or about (date) and does not need Varicella vaccine" or by serologic confirmation of Varicella immunity. The school shall accurately record the existence of any statements attesting to previous Varicella illness or the results of any serologic tests supplies as proof of immunity. The originals should be returned to the child/student's parent or guardian. If a child or student is unable to submit such a statement or serologic evidence, Varicella vaccine is required.***

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**Documentation of history of illness: Varicella (Chickepox)**

1. **A serologic confirmation of varicella immunity (positive varicella IgG result).**
2. **A written state from a physician, or a student's parent or guardian containing wording such as:**

***This is to verify that ________________________________________ had Varicella***
***(Child/Student Name)***
***illness (chickenpox) on or about _____________________________ and does not need***
***(Month / Year)***
***the Varicella vaccine.***

**______________________________**
**(Signature) (Relationship to child/student)**
**________ (Date)**

**Cisco College - CMA Checklist**

**Application, documents, receipt of payment, and proof of immunizations must be in hand prior to acceptance. Incomplete packets will be returned to the applicant, and may delay enrollment in the programs. A spot is saved for the applicant when the application is complete and payment is paid in full to Cisco College Business Office.**

**Student Name:** ________________________________________________

**Required Documents**

| | |
|---|---|
| **Copy of Driver's License:** | **State/DL #/Expiration:**<br>_______________________________ |
| **Copy of Social Security Card:** | **Social Security Number:**_____________ |
| **Receipt of Payment:** | **Date:** ___________________________ |

**Required Immunizations**

| | |
|---|---|
| **Hepatitis B (3 doses)** | **Dose 1:**___________ **Dose 2:**___________ **Dose 3:**_________<br>**Titer:**_____________ |
| **Tetanus/Diphtheria/ Pertussis (TDap; within the last 10 years)** | **Date:** |
| **Measles/Mumps/ Rubella (MMR; 2 doses)** | **Dose 1:**___________ **Dose 2:**____________<br>**Titer:**_____________ |
| **Varicella (Chicken Pox)** | **Dose 1:** ___________ **Dose 2:**____________<br>**Proof of having Chicken Pox Date:**_________________<br>**Titer:**________________ |
| **Tuberculosis Skin Test (TB; within the last 12 months)** | **Test Date:** _____________ **Date Read:** ____________<br>**Negative/Positive**<br>**If positive result from skin test; result from Chest X-ray:**_______ |
| **Annual Flu Shot** | **Date:**_______________ |
| **Meningococcal (Meningitis; required if under 22 years of age)** | **Date:**_______________ |

**By signing below, I read and understand Cisco College's refund policy, absence policy, and other information provided in the application. I understand no refund will be given on or after the first day of class. I understand partial refund will be given if a request to withdraw is given two weeks before the first day of class.**

**Student Signature** _______________________________________ **Date**_____________

**Cisco College**
**Certified Medication Aide**

**Nurse Aide Registry Check**

**I, ________________________________________, understand that I must undergo a Nurse Aide Registry Check with the Department of Aging and Disability Services, prior to entrance into the Certified Medication Aide Program. I am furnishing my information and understand that if my Nurse Aide Registry Check returns with questionable findings, it can result in not being able to enroll in the Medication Aide Program.**

_____________________________________ _____________________________

**Signature** **Date**

_____________________________________________________________________________

**Full Name (PRINT CLEARLY)**

_____________________________________________________________________________

**Other names (maiden, married)**

_____________________________________________________________________________

**Date of Birth**

_____________________________________________________________________________

**Social Security Number**

__________________________________________ ____________________________________

**Driver's License Number** **State Issued**

_____________________________________________________________________________

**Signature of Cisco College Witness**

*Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.*

**A Summary of Your Rights Under the Fair Credit Reporting Act**

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA.

**For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

·**You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• **You many limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information, about your federal rights, contact:**

| **TYPE OF BUSINESS:** | **CONTACT:** |
| --- | --- |
| 1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates<br>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB: | a. Consumer Financial Protection Bureau<br>1700 G Street, N.W. Washington, DC 20552<br>b. Federal Trade Commission: Consumer Response Center – FCRA<br>Washington, DC 20580<br>(877) 382-4357 |
| 2. To the extent not included in item 1 above:<br>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks<br>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act<br>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations<br>d. Federal Credit Unions | a. Office of the Comptroller of the Currency<br>Customer Assistance Group<br>1301 McKinney Street, Suite 3450<br>Houston, TX 77010-9050<br>b. Federal Reserve Consumer Help Center<br>P.O. Box. 1200<br>Minneapolis, MN 55480<br>c. FDIC Consumer Response Center<br>1100 Walnut Street, Box #11<br>Kansas City, MO 64106<br>d. National Credit Union Administration<br>Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO)<br>1775 Duke Street<br>Alexandria, VA 22314 |
| 3. Air carriers | Asst. General Counsel for Aviation Enforcement & Proceedings<br>Aviation Consumer Protection Division<br>Department of Transportation<br>1200 New Jersey Avenue, S.E. Washington, DC 20590 |
| 4. Creditors Subject to the Surface Transportation Board | Office of Proceedings, Surface Transportation Board<br>Department of Transportation<br>395 E Street, S.W. Washington, DC 20423 |
| 5. Creditors Subject to the Packers and Stockyards Act, 1921 | Nearest Packers and Stockyards Administration area supervisor |

| | |
|---|---|
| 6. Small Business Investment Companies | Associate Deputy Administrator for Capital Access<br>United States Small Business Administration<br>409 Third Street, S.W., 8th Floor<br>Washington, DC 20416 |
| 7. Brokers and Dealers | Securities and Exchange Commission<br>100 F Street, N.E.<br>Washington, DC 20549 |
| 8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations | Farm Credit Administration<br>1501 Farm Credit Drive<br>McLean, VA 22102-5090 |
| 9. Retailers, Finance Companies, and All Other<br>Creditors Not Listed Above | FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA<br>Washington, DC 20580 (877) 382-4357 |

TEXAS HEALTH & HUMAN SERVICES COMMISION
MEDICATION AIDE PROGRAM - MAIL CODE E416
P.O. BOX 149030
AUSTIN, TX 78714-9030
(512)438-2025

**GENERAL STATEMENT ENROLLMENT FORM**

All required forms must be completed and returned to the above address NO LATER THAN 20 DAYS after the date of the first scheduled class in which you are enrolled. Include a $25.00 NONREFUNDABLE combined application & examination fee made payable to the TEXAS HEALTH & HUMAN SERVICES COMMISSION (THHSC). If any of this portion of the application is incomplete, it cannot be processed.

1. NAME ____________________________________________________________

2. Social Security # ____________________________________________________

3. Mailing Address _____________________________________________________
   Street or P.O. Box City State Zip County

4. Rome Telephone (with area code)_____________________________________________

5. Date of Birth _____________________________________________________________

6. Name of Approved Training School ___________________________________________

7. Date of first scheduled class instruction _______________________________________

8. Are you able to read, write, speak and understand English? Yes_____________ No_______

9. Are you at least 18 years old? Yes_____ No ______

10. Submit an Experience Documentation Report from documenting current employment of the first official day of the training program in a facility licensed under Health and Safety Code Chapter 242 in the capacity of a CERTIFIED NURSE AIDE or in a Assisted Living Facility licensed under Health and Safety Code 247, State Supported Living Center, or ICF-IDD facility as a non-licensed direct care staff person. **(HOME HEALTH AGENCIES, STAFFING AGENCIES & HOSPITALS ARE NOT LICENSED FACILITIES UNDER THE MEDICATION AIDE REGULATIONS).**

11. Submit an Experience Documentation Form documenting 90 days of employment in an Assisted Living Facility under Health and Safety Code Chapter 247, State Supported Living Center or ICF-IDD facility as non-licensed direct care staff. This employment must have been completed within the 12-

month period preceding the first official class date. **AN APPLICANT EMPLOYED AS A CERTIFIED NURSE AIDE IS EXEMPT FROM THE 90 DAY REQUIREMENT.**

12. Submit a certified copy or photocopy which has been **NOTARIZED** as a true copy of an unaltered original high school graduation diploma or transcript or a general equivalency diploma.

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

14. Are you listed on the Employee Misconduct Registry (EMR) as unemployable?
Yes ____ NO___

15. Have you been convicted of a criminal offense listed in Texas Health & Safety Code 250.006?
Yes______ No______ if yes, list date ______________________ and conviction ___________.

16. Have you received a copy of the Medication Aide Training Program Rules? Yes____ No___.
If no, obtain 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 DADS obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask DADS 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.

**PLEASE READ CAREFULLY**

In making application to the Department of Aging & Disability Services Medication Aide Program for the issuance of a permit as 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 for the processing of my application. Upon issuance of a permit, I agree to bound by the Allowable and Prohibited Practices of a Permit Holder (95.105). [further understand that the materials submitted for consideration become the property of the Department and are nonrefundable. I am aware of the schedule of fees (95.109) 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 that I have provided in this application is truthful. I understand that to falsify any information submitted to DADS may result in voiding of this application and my failing to be granted a permit, or the revocation of my permit.

______________________________ ______________________________

**Date** **Signature of Applicant**

THE STATE OF )
COUNTY OF )

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

Given under my hand and seal of office, this _________ day of ____________, _____________

Notary Public in and for __________________ County, Texas or __________________________

______________________________
Signature of Notary

______________________________
Name of Notary

______________________________
Commission Expiration Date

EXPERIENCE DOCUMENTATION REPORT FORM
TEXAS HEALTH & HUMAN SERVICES COMMISION
MEDICATION AIDE PROGRAM - MAIL CODE E416
P.O. BOX 149030
AUSTIN, TEXAS 78714-9030

APPLICANT ______________________________ Social Security # ____________

TRAINING SCHOOL ____________________________________________________________
*********************************************************************************
Form must be filled out in its entirety by the individual certifying that the information submitted is correct.

I, ___________________________________________, certify that I have employed
**(FACILITY, ADMINISTRATOR, PROGRAM DIRECTOR/DON)**

_____________________________________ from ___________________ to ______________(applicant) 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 licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICFIDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

1. Place of Employment ____________________________________________________

2. Address ________________________________________________________________
   Street No. City State Zip

3. Phone Number. Including Area Code ________________________________________

4. Type of Facility ___________________________________________________________

5. Job Title of Applicant _____________________________________________________

6. Nurse Aide Certificate Number. (if applicable)_________________________________

7. Type of work performed (be specific) ________________________________________

On this ________________________________ day ____________________ of 20______,

In ____________________, _____________________________________.
I certify under penalty perjury that the information submitted is true and correct/

__________________________________________________
**SIGNATURE OF ADMINISTRATOR/PROGRAM DIRECTOR/DON**
Facility Vendor Number ___________________________

Before me, a Notary Public in ________________ - County, Texas on this day personally appeared
___________________________________________, known to me to be the
**ADMINISTRATOR/PROGRAM DIRECTOR/DON**
person 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 and seal of office this _______ day of _______, 20_________.

____________________________________________________(Signature of Notary)

TEXAS HEALTH & HUMAN SERVICES COMMISSION
MEDICATION AIDE UNIT
MAIL CODE E416
P.O. BOX 149030
AUSTIN, TX 78714-9030
(512)438-2025
FAX: (512)438-2052

**MEDICATION AIDE TRAINING PROGRAM VERIFICATION**

NAME OF SCHOOL____________________________________________________________

ADDRESS___________________________________________________________________

CITY, STATE, ZIP CODE _____________________________________________________

PHONE NUMBER WITH AREA CODE _______________________________________

NAME OF SCHOOL CONTACT PERSON ____________________________________

TITLE OF CONTACT PERSON _________________________________________________

PHONE NUMBER WITH AREA CODE ________________________________________

**********************************************************************

I_________________________________________________________, certify that
**(Program Coordinator/ Administrative Official)**
that students listed on attached roster have completed a 140 hour course instruction consisting of:

100 hours of classroom instruction and training;
20 hours of return skills demonstration laboratory;
10 hours of clinical experience including clinical observation and skills demonstration under the direct supervision of a licensed nurse in a facility; and,
10 hours in a return skills demonstration laboratory.

______________________________________________________________________
**Signature of Program Coordinator/Administrative Official**

School Seal                                                                                     Date______________