Advanced CMA Training Program

Administering Nasogastric/Gastrostomy Tube Feedings and Medications and Administering Metered Dose Inhalers and Nebulizer Treatments

Program Registration Information

Class Dates - (2nd Quarter): April 6, 2010 May 6, 2010

Registration Deadline: 5 days before class date

Time: **Registration 8:30 a.m. -- 8:55 a.m.**
Class begins 9:00 a.m. -- 4:00 p.m.

Location: **OAHCP (Oklahoma Association of Health Care Providers)**
200 NE 28th Street
Okla. City, Oklahoma 73105
(OAHCP office is not handicap accessible)

Approved: **By the Oklahoma State Department of Health**

This CMA advanced training program is a 10-hour program: 6-hours classroom/lab/written exam and 4-hours supervised practical training. Applicant must be a Certified Medication Aide listed in good standing on the Nurse Aide Registry.

CEU's: This program is approved for 8 hours of continuing education for Oklahoma Certified Medication Aides by the Oklahoma Nurse Aide Registry upon successful completion of program.

Classroom and Laboratory Training:
Participants will receive classroom instruction, practices skills and take the written test (i.e., must score at least 80% to pass).

Supervised Practical Training and Skills Demonstration:
To complete the course – your CMA will return to your facility to practice and demonstrate competence. Upon registration of your CMA to this program, your facility must designate a qualified person willing to serve as your clinical instructor and complete an instructor qualification form. You will also be asked to complete a clinical facility form. **OAHCP will obtain approval from the Oklahoma State Department of Health.** Your facility and instructor will then be approved to perform supervised practical training and skills testing for the OAHCP program. The designated instructor must agree to spend 4 hours providing practical training and have the trainee demonstrate at 100% proficiency on the following skills. (The skills list/forms will be provided).

1. Administering a bolus feeding via nasogastric/gastrostomy tube.
2. Administering medication via nasogastric/gastrostomy tube.
3. Administering medication while receiving a continuous feeding
4. Administering a metered dose inhaler
5. Administration of a nebulizer treatment.

Instructor Qualifications:
Instructors must be qualified as a physician, licensed nurse, pharmacist, respiratory therapist or speech therapist. Each instructor shall have one-year experience in her or his area of expertise. The program shall designate a registered nurse as the supervisor if a licensed nurse serves as an instructor.

Training Verification Form:
The clinical instructor will have **two weeks** following the classroom training to complete the four hours of supervised practical training and skills testing (i.e., exceptions to the two weeks may be made on a case by case basis). Once completed the skills lists must be returned to the OAHCP. Once completeness is verified, a "training verification form" will be returned to the clinical instructor to present to the CMA for verification of successful completion of the program.

Proof of Course Completion:
A copy of the "training verification form" or "state issued certificate" must be kept in the facility records as proof of course completion.

State Issued Certificate: **RECOMMENDED**:
Submit a copy of the "training verification form" with a $10.00 fee to the Oklahoma State Department of Health, Nurse Aide Registry, POB 268816, Oklahoma City, OK 73126-8816. The Nurse Aide Registry will place a notation on the registry and issue a certificate that bears an endorsement for the advanced training. To receive a "state issued certificate", mail a copy of the training verification form and $10.00 fee to: Oklahoma State Department of Health - Nurse Aide Registry – 1000 N.E. 10th Street – Oklahoma City, OK 73117-1299.

Cost of Program*:*
The cost of the program is **$105.00 per member facility** participant and **$135.00 per non-member** facility participant. Working lunch provided.

Registration and Payment Deadline:
Registration and payment must be received **5 working days before class date.** Payment must be made by company check or money orders, **no personal checks** will be accepted. **Payment must be received BEFORE class date. Cancellations received before 10 days of class date will receive full refund; cancellations received within 10 days of class date will receive credit minus $30 (member) or $40 (non-member) cancellation fee. Cancellations MUST BE FAXED to 405-524-8354. Substitutions may be made with proper paperwork prior to class.**

Program Time:
Check-in will be from 8:30 a.m. to 8:55 a.m. with class beginning promptly at 9:00 a.m. and adjourning at 4:00 p.m.
Working lunch provided.

Lodging:
Room reservations are the responsibility of each individual. Hotels listed are for your convenience.

- Best Western Broadway Inn and Suites – 6101 North Santa Fe Ave. – OKC - 405-848-1919 (mention OAHCP for discounted rate)
- Holiday Inn Hotel and Suites – 6200 N. Robinson – OKC - 405-843-5558 (mention OAHCP for discounted rate)

If you have questions please contact the Oklahoma Association of Health Care Providers by telephone: 405-524-8338 or Fax: 405-524-8354 or e-mail: mlynch@oahcp.org

REGISTRATION FORM

Advanced CMA Training Program

Administering Nasogastric/Gastrostomy Tube Feedings and Medications and Administering Metered Dose Inhalers and Nebulizer Treatments

Circle class date wanting to attend:

April 6, 2010 (OAHCP office-OKC)   **May 6, 2010** (OAHCP office-OKC)

Cost: **$105.00 per member** facility participant **$135.00 per non-member** facility participant

Please print:

1. Name of Certified Medication Aide Participant:____
2. **Attach a Copy of Current Certified Medication Aide Card**: CMA #: ___________________________
3. Expiration date of Certified Nurse Aide Certification (i.e., long term care, home health aide, developmentally disabled care aide): ______/______/______
4. Name of Facility:____
5. Facility Mailing Address: ____
6. City: ___________________________ State _________________ Zip __________________
7. Nursing Facility Phone #: (_____)__________________ FAX: (______)________________________
8. Facility Designated Clinical Instructor: ____
   a. Complete the Instructor Qualifications Form **(Attachment #1)**.
   b. If you are an LPN an RN must sign the instructor qualification form as your RN supervisor, and
   c. Attach copy of instructor's license.

FOR CREDIT CARD PAYMENT COMPLETE ATTACHED PAGE

Payment must be received BEFORE class date, no personal checks. Cancellations received before 10 days of class date will receive full refund; cancellations received within 10 days of class date will receive credit minus $30 (member) or $40 (non-member) cancellation fee. Cancellations MUST BE FAXED to 405-524-8354. Substitutions may be made with proper paperwork prior to class.

Please be sure to submit the following with this completed registration form **by the registration deadline date**: We must have all the information on the registration form and attachments for program approval:

1. Designate a facility instructor, complete instructor qualifications form **Attachment # 1**, & attach copy of license,
2. Attach a **COPY** of the Certified Medication Aides' certification card,
3. Completed clinical sites form **(Attachment #2)**, and
4. Company Check or Money Order.

Mail or Fax Registration to:

OAHCP 200 N.E. 28th Street Oklahoma City, OK 73105

405-524-8338 phone 405-524-8354 fax website: www.oahcp.org

Payment Information

Please check one of the following:

___ Check/ money order enclosed ___ Credit card (complete below)

___ Check/ money order in the mail

Credit Card Information

Facility name: ____

Individual name: ____

MasterCard ______ Visa ______ AMEX ______ Discover ______

Amount to be charged $__________

Card # ____ Expiration date: ____________

Cardholder name: __________________________________

Signature: ___________________________________

For Office Use Only

Date: ___________________________

Approval code: _______________________

Class number: ____________________

Initials: _______________

Attachment #1

Certified Medication Aide
Diabetes Care - Nasogastric/Gastrostomy/Oral Metered Dose Inhaler/Nebulizer
Instructor Qualifications Application

Program Type:

☐ CMA-Glucose Monitoring

____
Facility/Entity Name | Address | City | State | Zip

☐ CMA-Glucose Monitoring and Insulin Administration

____
Facility/Entity Name | Address | City | State | Zip

☐ CMA-Nasogastric/Gastrostomy/Oral Metered Dose Inhaler/Nebulizer

____
Facility/Entity Name | Address | City | State | Zip

Per 310:677-13-3. Instructor qualifications *(a) Each training program instructor shall be qualified as a physician, licensed nurse, pharmacist, respiratory therapist, speech therapist, or certified diabetes educator who may teach within her or his area of expertise or scope of practice. Each instructor shall have one year of experience in her or his area of expertise. The program shall designate a registered nurse as the training program supervisor if a licensed practical nurse serves as an instructor. (b)Other personnel from the health professions may supplement the instructor as required by the curriculum and approved by the Department.*

You may copy this form if you have more than three instructors.

Instructor: ______________________________

Indicate number of years' experience in area of expertise or scope of practice: ____________

Name and location of facility/entity where experience was obtained: ____________

____

Instructor: ______________________________

Indicate number of years' experience in area of expertise or scope of practice: ____________

Name and location of facility/entity where experience was obtained: ____________

____

Instructor: ______________________________

Indicate number of years' experience in area of expertise or scope of practice: ____________

Name and location of facility/entity where experience was obtained: ____________

____

RN Supervisor: ______________________________

(Only needed if LPN is instructing)

Please attach a copy of license on all instructors.

01/06

Attachment #2

CLINICAL SITES

Please check type of program.

☐ **CMA – Glucose Monitoring Training**

☐ **CMA – Glucose Monitoring and Insulin Administration Training**

☐ **CMA – Nasogastric/Gastrostomy/Oral Metered Dose Inhaler/Nebulizer Training**

Facility: ____

City/State/Zip: ____

Contact Person ______________________________ **Telephone #(___)**____________

Clinical Site/ Facility Name	**City**	**State**	**Zip**	**Telephone**
1. Contact Person:				
2. Contact Person:				
3. Contact Person:				
4. Contact Person:				
5. Contact Person:				
6. Contact Person:				

Comments____

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01/06