



MEDICATION ASSISTANT TRAINING PROGRAM
APPLICATION FOR APPROVAL
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60148 (04/2012)

Please mark the appropriate box: INITIAL APPLICATION RENEWAL APPLICATION

Type of program (Check all that apply):			
<input type="checkbox"/> Medication Assistant I			
<input type="checkbox"/> Medication Assistant II			
1. Name, address, and qualifications of program coordinator:			
Name		Telephone Number	
Address	City	State	ZIP Code
License Number	E-mail Address		
Will this individual serve as an instructor in the MA program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Name and address of facility/entity seeking MA training program approval:			
Name		Telephone Number	
Address	City	State	ZIP Code
3. Name and address of facility offering the theory portion (if different from #2 above):			
Name		Telephone Number	
Address	City	State	ZIP Code
4. Name and address of all clinical location(s) where the students will receive supervised clinical experience:			

5. Name and address of laboratory location(s):

6. Please list the name; phone number, email address, and address; qualifications; and North Dakota Nursing license number of **all** instructors:

7. Planned date of implementation of program (N/A if this is a renewal application):

8. Identify the teaching equipment available for simulation of medication administration and the audiovisual equipment available for instruction:

9. For the clinical experience, indicate the maximum number of students per facility and the instructor/student ratio:

COURSE CONTENT

10. Include a copy of the following with your application:

- a. The medication assistant training program course objectives
- b. Curriculum.
- c. All clinical skills checklists and/or evaluations of individual competency
- d. Unit tests (if applicable)
- e. Final test(s)
- f. Length of time spent on each unit
- g. Suggested timeline for course completion, including theory and clinical/laboratory portions.

11. Number of theory/classroom hours:

12. Number of clinical hours:

13. Number of laboratory hours (if applicable):

14. Describe the process used to conduct student testing to ensure competency in clinical and theory/classroom skills (including security of tests and test taking):

15. If this is a renewal application:

What has changed in the Med Assistant training program since your last review by the Department of Health?

16. What student feedback mechanisms do you use to determine if your course has properly prepared these students to pass medications?

I certify that the information given in this report is true and accurate.

Signature of program coordinator:

Date: