Thank you for inquiring about the Certified Medication Aide Program at Pontotoc Technology Center.

The purpose of the program is to provide and guide each student with the information in the study of drug administration, promoting awareness and safe methods to administer, enhance skills in a clinic environment and prepare them to successfully pass the State of Oklahoma Certification examination given though the Health Certification Project. Medication administration skills are taught in the classroom and laboratory, with clinical experience being provided through on the job training in long term care settings. This course is approved by the OSDH Nurse Aide Registry and meets all requirements to be a CMA in Oklahoma. Class includes 40 hours of theory & lab and 16 hours of clinical.

Within this packet you will find the required pre-requisite list which must be returned no later than the Wednesday prior to the first scheduled day of class. Please fill out the required paper work and return with a completed checklist to the BIS department as soon as possible. Refer to our website for a class dates and times www.pontotoctech.edu or pick up a hard copy of the schedule at PTC. Thank you again for choosing Pontotoc Technology Center and we hope to see you soon!

Business and Industry Programs
1. Classes will be held at Pontotoc Technology Center, 601 W. 33rd Street, Ada, Oklahoma.
   Items to be brought to class PRIOR to the first day:
   - Proof of a CURRENT CNA or CNA/HHA or DDCA card issued from the OSDH
   - Proof of at least 6 months experience as a Certified Nurse Aide prior to CMA training
   - Proof of a TB test within the past year
   - Copy of your GED, HS Diploma, or a recent college transcript and you must bring your Social Security card and driver’s license or other official photo id with you when you come to class. We must see the Social Security card itself for you to be in compliance with state regulations.
   - NOTE: AN OSBI BACKGROUND CHECK (WITHIN THE PAST YEAR) IS REQUIRED TO PERFORM CLINICALS AND SATISFACTORILY COMPLETE THE COURSE. (FORMS AVAILABLE AT THE EVENING ENROLLMENT DESK) COST: $15.00 PAYABLE TO THE OSBI.

2. Total training time for CNA: 56 hours
   The Certified Medication Aide (CMA) is allowed to perform the administration of medications in the following health care settings under the general supervision of a licensed nurse: long-term care, developmentally disabled, residential care, assisted living, adult day care facilities, as well as the correctional facilities. This course is approved by the OSDH-Nurse Aide Registry and meets all requirements to be a CMA in Oklahoma.
   (CPR for Health Care Providers {8 hrs} is recommended prior to this training but not required. Cost for CPR: see current schedule for pricing. Contact short-term enrollment at 310-2248 or 310-2266 prior to the start of the Nurse Aide class to enroll in a CPR class if you choose to attend.)

3. Fees for private pay or agency funded students:
   Please ask for current fee schedule.
   (One set of scrubs for clinical days will be required)

   **Those private pay students who live in a school district which has “opted out” of the Career Tech system and are not associated with any Career Tech school will be charged 200% of the fees for classes.

   NOTE: CMA textbooks are kept in our library. Books are checked out to students on a daily basis and never allowed out of the classroom. No tests will be administered until the text is checked back in and verified to be in acceptable condition. If deemed unacceptable, there will be a fee charged for the book prior to testing.

   Certification tests include a clinical test and a written test. Both are conducted at Pontotoc Technology Center. Testing for most classes is normally on the last day of class or the earliest possible date following the completion of class unless otherwise stated. The written test is administered via the internet with a printout of the results given to the student at the end of the test. If the on-line testing site is down a paper test would be administered that is mailed in or we will reschedule your online test at your request. Certification cards are normally mailed out from the Oklahoma Nurse Aide Registry within two weeks.

   If you have any questions regarding this health program contact:
   Health Programs Coordinator
   apogue@pontotoctech.edu

   Pontotoc Technology Center
   601 West 33rd Street
   Ada, Oklahoma 74820
   580-310-2248 BIS phone 580-310-2295 fax number

NON-DISCRIMINATION STATEMENT: Pontotoc Technology Center, in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and Title IX of the Education Amendment of 1972, does not discriminate on the basis of race, ethnicity, religion, national origin, age, gender, disability or veteran status in any of its policies, practices or procedures. These equal opportunity provisions include, but are not limited to admissions, employment, financial aid and student services.
OAC 310:677 OKLAHOMA STATE DEPARTMENT OF HEALTH

310:677-13-8. Certification and recertification

(a) Effective August 1, 2006, the following, to be evidenced by the aide's attestation, are prerequisites for certification as a medication aide:

(1) Minimum age: 18;
(2) Minimum education: high school or general equivalency diploma;
(3) Current Oklahoma nurse aide certification with no abuse notations;
(4) Experience working as a certified nurse aide for six months; and
(5) Physical and mental capability to safely perform duties.

(b) Application criteria and processing requirements for recertification are as follows:

(1) The certified medication aide shall submit a Recertification Application (ODH Form 717) that requires information to demonstrate compliance with 310:677-13-1(d).
(2) The Recertification Application (ODH Form 717) shall be accompanied by a five dollar ($5.00) fee.
(3) Each recertification shall be effective for twelve months from the expiration date of the medication aide's previous certification.
(4) The medication aide shall be required to retest if certification has expired by more than one year. The individual may obtain approval to take a retest by filing a Certified Medication Aide Retest Application (ODH Form 842) with a $10 nonrefundable fee. The aide shall retrain and test if the aide fails the retest or if certification has expired by more than three years.
(5) The Recertification Application (ODH Form 717) for a medication aide shall include documentation of continuing education equivalent to eight hours for every twelve months of certification, excluding the first year of certification.

(c) A certified medication aide who completes a Department-approved advanced training program and demonstrates competence may request a Department-issued certificate that bears an endorsement for the advanced training. When an advanced-training certificate is issued by the Department to a certified medication aide, a notation reflecting the advanced training shall be placed on the aide's record in the Nurse Aide Registry. The request shall be accompanied by the $5.00 certification fee required in this section and proof of training and competence on an application form that requires:

(1) The name and contact information for the certified medication aide; and
(2) The name of the training program, dates of attendance, details on the CMA's demonstration of competence, and copies of documents from the program confirming training and competence.

[Source: Added at 23 Ok Reg 559, eff 12-22-2005 (emergency); Added at 23 Ok Reg 2422, eff 6-25-2006; Amended at 24 Ok Reg 2045, eff 6-25-2007]
The following information should be provided to PTC **PRIOR** to the first class session. If all required documentation is not provided in the time frame stated, we reserve the right to move the student to the next scheduled class session. Our students must have the required documents to be able to attend clinical sessions at health facilities. Failure to have these documents means the student cannot be allowed to attend clinical training, and therefore the student will be incomplete on their required training which makes them ineligible to take the certification tests.

If any of the following information needs to be clarified with PTC, please notify us **before** the student attends class. You may contact us at **580-310-2248**.

Copy attached: (√)

<table>
<thead>
<tr>
<th>Enrollment Form</th>
<th>Copy of Valid Driver’s License or government issued Photo ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Social Security Card (Original card required - no copy will be made, but it will be checked as a required as a form of ID).</td>
</tr>
<tr>
<td></td>
<td>TB Skin Test – 1 required. <strong>TB Test must have taken place</strong> within 6 months of the dates of the class session you will be attending.</td>
</tr>
<tr>
<td></td>
<td>Copy of HS Diploma or GED or a College Transcript (THIS IS AN ABSOLUTE REQUIREMENT FOR CMA)</td>
</tr>
<tr>
<td></td>
<td>If you have none of the above documentations, and are attending <strong>CNA ONLY</strong>, you may schedule a TABE test here at PTC or use one from another testing facility. (<strong>TABE not accepted for CMA</strong>). The <strong>TABE MUST BE COMPLETED BEFORE THE COMMENCEMENT OF YOUR CLASS DATES</strong>.</td>
</tr>
<tr>
<td></td>
<td>OSBI Background check (must have been run within 6 months of the dates of the class session you will be attending)</td>
</tr>
<tr>
<td></td>
<td>NAME BASED only - No fingerprints required</td>
</tr>
<tr>
<td></td>
<td>You may obtain this form from us at the time you enroll. Ask for details about this documentation (re: required time to get it back from the OSBI, in OKC where the completed form will be mailed to, etc.)</td>
</tr>
</tbody>
</table>

Updated 9-2014

**AMERICAN HEART BASIC LIFE SUPPORT FOR HEALTH CARE PROVIDERS IS**

**HIGHLY RECOMMENDED** BUT **NOT REQUIRED PRIOR TO ATTENDING**
# Enrollment Form

**Please complete this section in full**

## Course Details

<table>
<thead>
<tr>
<th>Course Date</th>
<th>Course Name</th>
</tr>
</thead>
</table>

## Personal Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SSN</th>
<th>E-Mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

## Address Information

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

## School District

- [ ] Ada
- [ ] Allen
- [ ] Byng
- [ ] Latta
- [ ] McLish
- [ ] Pickett-Center
- [ ] Roff
- [ ] Sasakwa
- [ ] Stonewall
- [ ] Tupelo
- [ ] Vanoss
- [ ] Other

## Education Level

- [ ] Less than a H.S. diploma
- [ ] High School graduate
- [ ] Some college, no degree
- [ ] Technical diploma
- [ ] Associate degree
- [ ] Bachelor degree
- [ ] Master degree
- [ ] Doctorate degree
- [ ] GED

## Payment Method

- [ ] Cash
- [ ] Check
- [ ] Money Order
- [ ] Discover
- [ ] Master Card
- [ ] Visa

## Employer’s Name or Funding Agency

-or Paying Own Fees (write Self-Pay)

## Race

- [ ] American Indian or Alaska Native
- [ ] Black or African American
- [ ] Hispanic/Latino
- [ ] White
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] Other

## Gender

- [ ] Male
- [ ] Female

---

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---

**This section is required for Chickasaw Nation Employees only.**

Please check one of the divisions below:

### Headquarters (A-L)

- [ ] Division of Administrative Services
- [ ] Division of Aging
- [ ] Division of Arts and Humanities
- [ ] Division of Communications
- [ ] Division of Education and Training
- [ ] Division of Facilities and Support
- [ ] Division of Heritage Preservation

### Headquarters (M-O)

- [ ] Division of Commerce (Chickasaw Enterprises)
- [ ] Division of Housing & Tribal Development
- [ ] Division of Health Systems

**Chickasaw Employee Signature**

**Name of Your Department**

**Job Title**

I acknowledge that my department will be billed for the class for which I am enrolling. I understand that if I cannot attend, I must give at least twenty-four (24) hours notice or my department will be billed regardless of attendance.

**Supervisor Signature:**

**Account Number:**

---

**Return To:** Chickasaw Nation Training Division

---

**Note:** All Enrollment forms should be faxed to (580) 310-2295 if not completed in person.
CERTIFIED MEDICATION AIDE

STATEMENT OF ATTESTATION

I attest that I, ___________________________, meet all of the following requirements for certification as a medication aide (please initial beside each):

_____ I am at least eighteen years of age.

_____ I have a high school diploma or a general equivalency diploma (GED).

_____ I have a current Oklahoma nurse aide certification with no abuse notations.

_____ I have at least six months experience working as a certified nurse aide.

_____ I have the physical and mental capability to perform the duties of a certified medication aide.

_____________________________  ____________________________
Candidate Signature              Date of Signature

_____________________________
Candidate Name (printed)

_____________________________
Signature of Test Site Coordinator/Proctor

1500 West Seventh Avenue
Stillwater, OK  74074-4364
www.okcareertech.org
(405) 377-2000 • Fax: (405) 743-6809
Pontotoc Technology Center
PPD/TST Form

Student Name: __________________________________________

Date: __________     Time: __________

Location (circle):  Left  or  Right  Forearm  or  Trapezius

Medication used: __________

Lot #: __________

Signature: ____________________________

Reading

Date: __________     Time: __________

Reactive____   Non-Reactive____

Signature: ____________________________

Pontotoc Technology Center
PPD/TST Form

Student Name: __________________________________________

Date: __________     Time: __________

Location (circle):  Left  or  Right  Forearm  or  Trapezius

Medication used: __________

Lot #: __________

Signature: ____________________________

Reading

Date: __________     Time: __________

Reactive____   Non-Reactive____

Signature: ____________________________
CONSENT FOR HEALTH PROGRAMS DRUG/ALCOHOL SCREEN:
(Applicant will read each statement and sign below. Pontotoc Technology Center reserves the right to deny a student admission to any Medical Program if student refuses to sign this consent form.)

1. In applying for admission to any medical program at Pontotoc Technology Center, I understand that a drug/alcohol screening test could be administered based on suspicion of drugs or alcohol at school or at a clinical site.

2. The drug/alcohol test will consist of an initial screening test and a confirmatory test for any sample that produces a positive result. The drug/alcohol testing is to be done within 24 hours of suspicion. Once you enter the drug testing facility, you cannot leave the facility until the sample is collected.

3. The undersigned hereby authorizes the designated drug testing facility to perform a drug/alcohol screening test as a requirement to stay in any medical program if suspicion exists.

4. I understand the presence of chemical substances in my body fluids may result in dismissal from any medical program at Pontotoc Technology Center.

I hereby authorize that the results of the drug/alcohol screening test be given to officials at Pontotoc Technology Center for review of continued enrollment in the medical programs. I release and hold Pontotoc Technology Center, its agents, and employees harmless for any action in taking or testing of the sample. I also release and hold harmless Pontotoc Technology Center, its board of education, superintendent, management, instructors, or any other agent or employee for the use of any information received as a result of the screening test process.

I also acknowledge that an offer of admission and continued enrollment to any health program will be contingent upon my submission to and the subsequent results of this drug/alcohol screen.

___________________________________
Printed Name

____________________________________
Applicant Signature

____________________________________
Date
Hepatitis B Declination

Name: ____________________________________

Program: ________________________________

Declination
I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B (HBV) infection. I have received information about hepatitis B vaccine, and I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I further understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with hepatitis B vaccine, I will make my own arrangements to receive the vaccine.

- I decline hepatitis B vaccine.

- I have already received the hepatitis B vaccine.

Signature: ________________________________    Date: __________________
Type of search requested:  
- Name Based - $15.00  
- Sex Offender - $2.00  
- Mary Rippy Violent Offender - $2.00  
- State Fingerprint-based - $19.00  
  * Must provide fingerprint card.  
  * Includes name based search.

Acceptable forms of payment:  
- Cash  
- Cashier's check / money order  
- Business check (no personal checks accepted)  
- Credit card (For Visa, MasterCard and Discover, security code is 3 digits on back of card.  
  For American Express, security code is 4 digits on front. These are the only cards accepted.)

Credit card #: _____________________________  
Expiration date: _____________________________  
Security code: _____________________________

Card holder: _____________________________  
Card holder signature (required): _____________________________

Requestor's information: (Type or print clearly in blue or black ink)

Name: _____________________________
Street address: _____________________________
City: _____________________________
State: _____________________________
Zip: _____________________________
Phone number: ( ) ______________
E-mail address: _____________________________

Purpose of request: _____________________________

Requestors outside of the United States are strongly encouraged to provide an e-mail address for purposes of correspondence.

Subject information: (Type or print clearly in blue or black ink)

Name: _____________________________
Last: _____________________________
First: _____________________________
Middle: _____________________________

Alias/Maiden name(s): _____________________________

Date of birth: _____________________________ (MM/DD/YYYY).  
If date of birth is unavailable, include exact age of subject.

Race: _______  
Sex: _______  
Social security number: _____________________________

Search results (please do not write in the spaces below):

Oklahoma State Bureau of Investigation  
Computerized Criminal History

Oklahoma Department of Corrections  
Sex Offender

Oklahoma Department of Corrections  
Violent Offender

Unless fingerprint cards are provided, record information is furnished solely on the basis of name or description similarity with the subject of your inquiry.
HEALTH PROGRAMS CRIMINAL RECORDS CHECK POLICY

Health care providers are entrusted with the health, safety, and welfare of patients; have access to controlled substances and confidential information; and operate in settings that require the exercise of good judgment and ethical behavior. Clinical facilities area increasingly required by accreditation agencies, such as Joint Commission for Accreditation of Healthcare Organizations (JACHO), to conduct background checks on individuals who provide services within the facility and especially those who supervise records check for all prospective employees for positions where the individual will be caring for older adults or children.

Clinical learning experiences are an essential element of the curriculum of health care programs. All students enrolled in Pontotoc Technology Center’s health care programs must successfully complete a criminal records check as a criterion for participating in clinical courses. Participation in clinical courses is required for progression and completion of health care programs.

The check must be completed by the Oklahoma State Bureau Investigation (OSBI). The criminal records check must be completed within the six months immediately prior to the student’s entry into clinical courses. The student shall be responsible for all costs associated with the criminal records check.

The information provided in the criminal records report will only be used to evaluate the student’s qualifications for entry into clinical courses. Reports will be kept in secured confidential files separate from the student’s academic file with access limited to approved members of the Adult Training and Development Division.

Criminal record reports will undergo administrative review. If a student has been convicted of or pled guilty to a disqualifying offense (or any substantially equivalent offenses in any state), the student may be unable to complete clinical learning experiences and may therefore be disqualified from admission, readmission, or progression in the health care program. Some of the disqualifying offenses are absolute bars while others might bar the student from admission, readmission or progression in the program. The absolute and potentially disqualifying offenses are listed in the table attached to this packet.

In the event that the student’s background check includes a disqualifying offense, the student will be asked to schedule a meeting with the Program Coordinator to discuss the information received. If the background check identifies offenses that the student considers incorrect, the concerns or issues must be addressed, by the student, to the Oklahoma State Bureau Investigation for resolution. If the background check identifies offenses that may preclude, admission, the student will be given an opportunity to respond to the information. Relevant considerations may include but are not limited to: the date, nature and number of convictions; the relationship the conviction bears to the duties and responsibilities of the health care provider; and successful efforts toward rehabilitation. The decision to allow or disallow participation in a clinical course for a student whose background check includes a disqualifying offense is solely at the discretion of the Program Coordinator and the Director of Business and Industry.

All students who are admitted to a health care program have a continual obligation to report any criminal conviction that may impact the student’s continued ability to participate in the clinical program to the Program Coordinator or the Director of Business and Industry within 30 days of its occurrence. Failure to do so will result in immediate dismissal from the program.
# Absolute* and Potentially Disqualifying Offenses That May Prevent an Applicant from Obtaining a Health Related Oklahoma Licensure or Certificate

<table>
<thead>
<tr>
<th>Absolute Disqualifying Offense</th>
<th>Compelling Prostitution</th>
<th>Unlawful Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggravated Murder *</td>
<td>Promoting Prostitution</td>
<td>Endangering Children</td>
</tr>
<tr>
<td>Murder*</td>
<td>Procuring</td>
<td>Contributing to the Unruliness or Delinquency of a Child</td>
</tr>
<tr>
<td>Voluntary Manslaughter*</td>
<td>Prostitution</td>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Involuntary Manslaughter</td>
<td>Disseminating Matter Harmful to Juveniles</td>
<td>Prohibition of Conveyance of Certain Items onto Grounds of Detention Facility or Mental Health or Mental Retardation and Developmental Disabilities Facility.</td>
</tr>
<tr>
<td>Felonious Assault*</td>
<td>Pandering Obscenity</td>
<td>Carrying Concealed Weapons</td>
</tr>
<tr>
<td>Aggravated Assault</td>
<td>Pandering Obscenity Involving a Minor</td>
<td>Having Weapon while under Disability</td>
</tr>
<tr>
<td>Failure to Provide for a Functionally Impaired Person</td>
<td>Pandering Sexually Oriented Matter Involving Minor</td>
<td>Improperly Discharging a Firearm/Habitation or School</td>
</tr>
<tr>
<td>Aggravated Menacing</td>
<td>Illegal Use of a Minor in Nudity-Oriented Material or Performance</td>
<td>Corrupting Another With Drugs</td>
</tr>
<tr>
<td>Patient abuse or neglect</td>
<td>Aggravated Arson*</td>
<td>Drug Trafficking Offenses</td>
</tr>
<tr>
<td>Kidnapping*</td>
<td>Aggravated Robbery*</td>
<td>Illegal Manufacturing of Drugs</td>
</tr>
<tr>
<td>Abduction</td>
<td>Robbery</td>
<td>Funding Drug Trafficking</td>
</tr>
<tr>
<td>Child Stealing</td>
<td>Aggravated Burglary*</td>
<td>Illegal Administration or Distribution of Anabolic Steroids</td>
</tr>
<tr>
<td>Criminal Child Enticement</td>
<td>Burglary</td>
<td>Drug Abuse</td>
</tr>
<tr>
<td>Coercion</td>
<td>Breaking and Entering</td>
<td>Permitting Drug Abuse</td>
</tr>
<tr>
<td>Extortion</td>
<td>Theft, Aggravated Theft</td>
<td>Deception to Obtain Dangerous Drugs</td>
</tr>
<tr>
<td>Rape*</td>
<td>Unauthorized Use of a Vehicle</td>
<td>Illegal Processing of Drug Documents</td>
</tr>
<tr>
<td>Sexual Battery*</td>
<td>Unauthorized Use of Property/Unauthorized Access to Computer Systems</td>
<td>Adulteration of Food</td>
</tr>
<tr>
<td>Corruption of a Minor</td>
<td>Passing Bad Checks</td>
<td></td>
</tr>
<tr>
<td>Gross Sexual Imposition*</td>
<td>Misuse of Credit Cards</td>
<td></td>
</tr>
<tr>
<td>Sexual Imposition</td>
<td>Forgery</td>
<td></td>
</tr>
<tr>
<td>Importuning</td>
<td>Medicaid Fraud</td>
<td></td>
</tr>
<tr>
<td>Voyeurism</td>
<td>Securing Writings by Deception</td>
<td></td>
</tr>
<tr>
<td>Public Indecency</td>
<td>Insurance Fraud</td>
<td></td>
</tr>
<tr>
<td>Felonious Sexual Penetration</td>
<td>Receiving Stolen Property</td>
<td></td>
</tr>
</tbody>
</table>

*Absolute disqualifying offense