OHIO BOARD OF NURSING
MEDICATION AIDE PILOT PROGRAM APPLICATION
Pilot Program: May 1, 2006 – June 30, 2007

_____ _____
(Applicant Facility Name) *(Facility Administrator Name)*

_____ _____
(Facility Address) *(Administrator Telephone)*

_____ _____
(Facility Telephone Number) *(Registered Nurse Name)*
(Responsible for oversight of nursing care for facility)

TYPE OF FACILITY: *(Check One)*
- ❑ Nursing Home
- ❑ Residential Care Facility (RCF)

_____
(Registered Nurse Telephone)

Anticipated Start Date for Use of CMAs _____

Licensed capacity of facility _____ Average annual census _____ Number of years facility licensed _____

Estimated number of certified medication aides (CMAs) to be used to administer medication _____

Estimated number of residents for whom CMAs will administer medication _____

General acuity level of residents: _____

Please identify any special population(s) your facility serves: _____

_____

_____

_____

THE FOLLOWING ATTACHMENTS MUST BE SUBMITTED WITH THE APPLICATION

- ❑ Copies of the two most recent Ohio Department of Health annual surveys or inspections
- ❑ Copies of the facility plan to utilize CMAs, which includes the following:

1. Method of providing written notice of the facility's participation in the Pilot Program and the plan to use CMAs.
2. Method of obtaining informed consent from each resident for administration of prescription medications by CMAs during the Pilot Program
3. Explanation of how the following information will be provided to facility residents
   - Training and Education requirements for CMAs
   - Types of medication that can be administered by CMAs
   - The process for nursing delegation
   - The right of the resident to refuse to have prescription medications administered by a CMA

FOR-PROFIT FACILITY: Statement of ownership, including whether common owner operates other nursing home and/or residential care facilities, with contact information for owner or owner's designated representative

_____

_____

_____

_____

_____ _____

Name *Telephone*

NOT-FOR-PROFIT FACILITY: List of Governing Board members with contact information for designated representative

_____

_____

_____

_____

_____

_____

_____ _____

Name *Telephone*

RCFs Only: Mark "not applicable," or specify how the RCF is affiliated with a nursing home, i.e., common ownership, shared physical location, or other means: _____

_____

_____ *(Name of facility), as a condition of participation in the Medication Aide Pilot Program, hereby agrees to the following:*

1. *The Applicant Facility will fully cooperate with and consent to announced or unannounced site visits by the Ohio Board of Nursing staff, which may include review of resident records.*

2. *The Applicant Facility will comply with all of the requirements of the Medication Aide Pilot Program as set forth in Sections 4723.61 to 4723.69 of the Revised Code, and the administrative rules adopted thereunder.*

_____ _____

Signature of individual authorized to sign legal documents for facility *Title*

_____ _____

Printed Name *Date*