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| DEPARTMENT OF HEALTH SERVICESDivision of Quality AssuranceF-62586 (08/2022) | **STATE OF WISCONSIN** |

**CHALLENGE EXAM APPLICATION FOR NURSE AIDE / MEDICATION AIDE**

### This application reports the successful completion of a Wisconsin approved medication aide training program by a nurse aide previously included on the Registry. Successful completion of the medication aide training program allows a nurse aide to administer medications in a federally certified skilled nursing home.

### The personal information will only be used to determine your nurse aide employment eligibility.

### This application will not be processed if it is incomplete, unsigned or illegible.

### Questions about completion of this form may be directed to 608-225-2528.

### SUBMIT THE FOLLOWING ITEMS WITH THIS APPLICATION:

* Letter of recommendation from DON, Nursing Home Administrator, and two (2) charge nurses.
* Transcripts that document medication administration courses attended (if applicable).
* Certification of Med Aide from another state and criteria to be a Med Aide in that state (if applicable).
* SUBMIT ALL MATERIALS TO: **Division of Quality Assurance**

 **ATTN: Pharmacy Consultant**

 **P.O. Box 2969**

 **Madison, WI 53701-2969
 Email:** dhswidqa\_natcep@dhs.wisconsin.gov
 **Fax:** **608-267-0352**

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| APPLICANT INFORMATION |
| Name – Applicant | Date Application Completed |
|  |  |
| Birth Date | Registration Number | Phone Number (Home) | Phone Number (Work) | Email |
|  |  |  |  |  |
| Mailing Address | City | State | Zip Code |
|  |  |  |  |
| Name – Employer |
|  |
| Address – Employer |
|  |
| Preferred Testing Location |
|  |
| RELEASE |
| I authorize or its appointed representative, to release the information on this form to the Wisconsin Nurse Aide Directory. I also authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , or its representative, to release necessary information regarding my performance in the Nurse Aide / Medication Aide course to my current employer or any future prospective employer. |
| SIGNATURE – Applicant | Date Signed |
| VERIFICATION |
| I have verified this applicant’s background and have determined that the applicant is:  [ ]  Eligible  [ ]  Not Eligible for Challenge Testing. The applicant is required to participate in the following:  [ ]  Final Exam  [ ]  Practicum Exam |
| **SIGNATURE** – Pharmacy Consultant | Title      | Date Verified |