

STATE OF NEW MEXICO

(505) 841-8340

(505) 841-8347 Fax



Board of Nursing

6301 Indian School NE, Suite 710
Albuquerque, NM 87110

**PAYMENT SHEET
CERTIFIED MEDICATION AIDE PROGRAM
INITIAL APPROVAL APPLICATION**

**APPLICATION MUST BE ATTACHED
ALL FEES ARE NON-REFUNDABLE**

PROGRAM FACILITY NAME: _____

PROGRAM FEE:

INITIAL PROGRAM APPLICATION \$ 250.00 _____

**DEBIT CARDS ARE NOT ACCEPTED AS CREDIT CARDS
IF YOU ARE USING A CREDIT CARD PLEASE CHECK ONE OF THE FOLLOWING:**

MASTERCARD ____ VISA _____

CREDIT CARD# _____ - _____ - _____ - _____

EXPIRATION DATE: Month _____ Year _____

LEGAL SIGNATURE: _____ DATE: _____

**IF YOU ARE PAYING WITH A MONEY ORDER OR CASHIER'S CHECK
PLEASE MAKE CHECK PAYABLE TO:
THE NEW MEXICO BOARD OF NURSING**

STAPLE MONEY ORDER/CASHIER'S CHECK TO BOTTOM OF THIS SHEET. STAPLE ONCE ONLY!

STATE OF NEW MEXICO

(505) 841-8340
(505) 841-8347 Fax



Board of Nursing

6301 Indian School NE, Suite 710
Albuquerque, NM 87110

INITIAL APPROVAL APPLICATION
CERTIFIED MEDICATION AIDE PROGRAM

SUBMIT ONE (1) COPY OF REQUIRED MATERIALS ALONG WITH THE COMPLETED APPLICATION AND FEE AS FOLLOWS:

INITIAL PROGRAM REVIEW FOR APPROVAL FEE \$250.00

(PLEASE PRINT OR TYPE)

DATE OF APPLICATION: _____

NAME OF AGENCY PROGRAM: _____

ADDRESS: _____ PHONE: _____

ADMINISTRATOR: _____ NURSE EDUCATOR: _____

MEDICAL DIRECTOR: _____

NEW MEXICO DEPARTMENT OF HEALTH LICENSURE: _____

Date of last survey: _____ Expiration date of current DOH license: _____

OBJECTIVES:
(ATTACH A COPY OF THE PROGRAM OBJECTIVES)

1. There are written objectives which serve as a basis for the planning, implementation, and evaluation of the program. YES NO
2. Person who developed objectives: _____ Date developed: _____
3. The objectives are reviewed annually and revised as necessary by the nurse educator. YES NO

CURRICULUM:

1. Is your facility using a Board Approved standardized curriculum? YES NO
2. The curriculum extends over a period of time sufficient to provide essential, sequenced learning experiences which enable a student to develop competence consistent with principles of learning and sound education practice. YES NO

Number of classroom hours: _____

Clinical Practice Hours: _____ Number of hours of theory: _____



**INITIAL APPROVAL APPLICATION
CERTIFIED MEDICATION AIDE PROGRAM (cont'd)**

- 3. Briefly describe the objectives of the clinical experience and the type of clinical experience to be offered. _____
- 4. Briefly describe the role of the RN nurse educator in the supervised clinical experience. _____
- 5. What is the ratio of students to faculty in the supervised clinical experience? _____
- 6. The curriculum provides for instruction in the subject areas listed in the rules and regulations.
YES NO
IF NO, please explain: _____
- 7. Is there a written systematic plan for curriculum and program evaluation? YES NO
IF NO, please explain: _____
- 8. The plan was developed by: _____

ATTACH A COPY OF THE PROGRAM CURRICULUM INCLUDING:

- A. Unit objectives
- B. Content outline
- C. Teaching learning activities (i.e., textbooks, lecture, demonstration, simulations, films, practice training assignments)
- D. Hours to be spent on each content area.
- E. Plan for curriculum and program evaluation
- F. Evaluation tools (written and clinical proficiency)

COMPLETE THE FOLLOWING:

DATE OF ACTIVITY MO/DATE(S)/YEAR	TITLE OF ACTIVITY	APPROVAL AGENCY	CONTACT HOURS



**INITIAL APPROVAL APPLICATION
CERTIFIED MEDICATION AIDE PROGRAM (cont'd)**

Clinical Preceptor (s): Add additional sheets if needed

Name: _____ License No./Expiration date: _____

Name: _____ License No./Expiration date: _____

Name: _____ License No./Expiration date: _____

ADMINISTRATION AND ORGANIZATION:

1. There is a current organizational chart showing the position of the training program within the overall structure of the facility. YES NO
2. The organization chart indicates the lines of authority and responsibility and channels of communication. YES NO

ATTACH A CURRENT ORGANIZATIONAL CHART

1. Are there sufficient resources available to the training program to meet the needs and purpose of the program? YES NO
2. Is there a nurse educator to administer the training program? YES NO

Please describe the nurse educator's administrative responsibilities:

QUALIFICATIONS AND COMPETENCY OF FACULTY

(PLEASE ATTACH A COPY OF THE NURSE EDUCATOR(S) AND OTHER FACULTY RESUMES)

PLEASE ATTACH THE FOLLOWING:

1. POLICIES IN EFFECT FOR INSTRUCTION AND EVALUATION OF STUDENT ACHIEVEMENT, GRADING, AND PROGRESSION.
2. THE EVALUATION METHODS (WRITTEN EXAMINATION, STUDENT PRESENTATIONS OR DEMONSTRATION OF COMPETENCY EVALUATION AND WHEN DONE).
3. JOB DESCRIPTION/ROLE OF THE CERTIFIED MEDICATION AIDE.
4. QUALITY ASSURANCE PROCEDURES FOR REPORTING COMPLAINTS AGAINST A CERTIFIED MEDICATION AIDE.



**INITIAL APPROVAL APPLICATION
CERTIFIED MEDICATION AIDE PROGRAM (cont'd)**

NURSE EDUCATOR:

1. The nurse educator is a Registered Nurse licensed to practice in New Mexico or has compact license. YES NO If yes, please give current license number: _____
2. The nurse educator has at least two (2) years of recent nursing practice experience, within the last five (5) years. YES NO
3. The nurse educator is responsible for instruction and evaluation of student achievement, grading and progression. YES NO

RECORDS:

1. The nurse educator's record includes current professional education, continuing education, and experience and data regarding maintenance of clinical and teaching experience and licensure in New Mexico. YES NO
2. The students' records include admission data, evaluation data, documentation of clinical experience and final course grade. YES NO

**ATTACH APPROPRIATE FEE AS INDICATED ON PAYMENT FORM.
FEES ARE PAYABLE TO THE NEW MEXICO BOARD OF NURSING.**

ACCEPTABLE FORMS OF PAYMENT ARE:

- MONEY ORDER, CASHIER'S CHECK, VISA OR MASTERCARD.
- CASH IS ACCEPTED BY WALK IN ONLY AND FOR THE EXACT AMOUNT.
- NO PERSONAL CHECKS, DEBIT CARDS/CHECK CARDS OR DEMAND DRAFTS ACCEPTED.

HAVE YOU REVIEWED THE BOARD OF NURSING RULES REGARDING CERTIFIED MEDICATION AIDES? YES NO

SUBMITTED BY:

_____	_____	_____
NURSE EDUCATOR SIGNATURE	NURSE EDUCATOR (PRINT)	DATE
_____	_____	_____
ADMINISTRATOR SIGNATURE	ADMINISTRATOR (PRINT)	DATE
_____	_____	_____
DIRECTOR OF NURSING SIGNATURE	DIRECTOR OF NURSING (PRINT)	DATE



**INITIAL APPROVAL APPLICATION
CERTIFIED MEDICATION AIDE PROGRAM**

CHECKLIST:

- Reviewed Board of Nursing Rules for Certified Medication Aides.
- Completed Application in its entirety and attached required documents
- Resumes of Nurse Educators and other faculty including preceptors attached
- Organization Chart attached
- Curriculum attached
- Fee attached payable to the NM Board of Nursing

PROCESS:

- Mail the information to the BON with fee attached
- The application will be reviewed at the next scheduled Medication Aide Advisory Committee (MAAC).
- Based on the MAAC's recommendation, approval will be requested from the board at their next scheduled meeting at www.bon.state.nm.us
- A letter will be mailed to you with Board approval or request for more information
- Nurse educator will need to call BON Assistant Director Unlicensed Assistive Personnel to schedule the required nurse educator orientation
- Nurse Educator or substitutes are welcome to attend and/or join the quarterly meeting of the MAAC. For committee dates, please check the board of nursing website.