

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
RENEWAL / RE-ACTIVATION APPLICATION**

Application must be completed in full and attached.
FEES ARE NOT REFUNDABLE

NAME: _____

ADDRESS (city, state, zip code): _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DATE OF BIRTH: _____

INDIVIDUAL FEES (check all applicable):

Renewal of medication aide certificate(s)	\$45.00 _____
Re-activation of a lapsed certificate	\$50.00 _____
Re-instatement of a lapsed certificate following board action	\$60.00 _____

PERSONAL CHECKS ARE NOT ACCEPTED
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 _____

AMOUNT: _____

SIGNATURE: _____ DATE: _____

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

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

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CERTIFIED MEDICATION AIDE
RENEWAL / REACTIVATION APPLICATION

Incomplete applications will be returned to the address on this form.

Full legal name will appear on the certificate. Name change requires recorded marriage certificate or court order.

LEGAL NAME: _____ CERTIFICATE NUMBER: _____

MAILING ADDRESS: _____
(Street Address or Post Office Box #)

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____
MM / DD / YYYY

EMPLOYMENT: Employer must be a board approved Certified Medication Aide Program.

Board Approved Employer: _____

Immediate Supervisor: _____ Employer's Phone #: _____

Check the applicable boxes below to acknowledge meeting requirements for renewal or re-activation.

1. Have you been employed for 100 hours as a Certified Medication Aide in the past 24 months?
(You may be randomly selected for an audit of your hours) YES NO
2. Do you have documentation that you completed a minimum of 16 Continuing Education Clock Hours for renewal or re-activation?
(You may be randomly selected for an audit of your continuing education) YES NO
3. If you are a CMA II, do you have documentation of a minimum of 20 (Total) Continuing Education clock Hours for renewal or re-activation? (You may be randomly selected for an audit of your continuing education) YES NO
4. If you are re-activating, have you attached a letter from your agency including the date you last worked as a Certified Medication Aide?
 YES NO
5. If you are reinstating after board action against your certification, have you completed all board requirements?
 YES NO If NO, please attach a separate page with an explanation.

DISCIPLINARY ACTION: Since your last renewal have you had disciplinary action or have any action pending against you by: any licensing jurisdiction including New Mexico, the USDA, Drug Enforcement Agency, any state drug enforcement authority, or a branch of the US Military?

YES NO If YES, give date(s) _____ and state(s) _____

FELONY CONVICTION: Since your last renewal, have you been convicted of a felony or are you now charged with any felony in any state or federal court? Please include any felony charges that resulted in a guilty plea, nolo contendere plea or a deferred or suspended sentence. A felony is generally a criminal charge with potential punishment of at least one year in prison or jail. If in doubt, disclose the charge or conviction with a copy of all relevant documents. Failure to properly disclose a charge or conviction may result in disciplinary action being taken against you by the Board of Nursing.

YES NO If YES, give date(s) _____ and state(s) _____

I hereby make application for re-certification or re-activation as a Certified Medication Aide in accordance with the State of New Mexico Nursing Practice Act and enclose the required fee. I certify, under penalty of perjury, to the truth and accuracy of all statements, answers and representations made on this application.

Printed Legal Name: _____

Date: _____

Legal Signature: _____