UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Medication Aide Certified

Clear Form

APPLICANT INFORMATION

Full Legal Name: _____ _____ _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: _____ State: _____ Zip: _____

Phone: (____) _____ –_____ Email: _____
Note: All Division notices and communication will be sent to this email.

Please select one:

- ☐ I am a United States citizen or a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card: _____ _____ _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying with this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.
DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No	Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
2. ☐ Yes ☐ No	Do you CURRENTLY have **any criminal action active or pending**?
3. ☐ Yes ☐ No	WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?
4. ☐ Yes ☐ No	Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certifications issued by any state in which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No The Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4, you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www.npdb.hrsa.gov*.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: _____

NATIONAL MEDICATION AIDE CERTIFICATION EXAM

Select One:

- ❑ I have taken the MACE for another state and have requested verification of licensure, including exam and education information.
- ❑ I have taken the MACE for Utah, my test ID number is: _____

UTAH DEPARTMENT OF COMMERCE
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CRIMINAL HISTORY DISCLOSURE STATEMENT

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at: https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement . Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature: _____ **Date:** _____

Printed Name: _____

Please see our website, www.dopl.utah.gov/fingerprints.html, for required information and approved locations to obtain fingerprints.

Completed fingerprint cards can be mailed to:

Division of Professional Licensing
P.O. Box 146741
Salt Lake City, UT 84114-6741

REVIEW OF YOUR CRIMINAL RECORD: If you wish to review or challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI. Please see their website at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

If you wish to review or challenge the accuracy of the information in your BCI record, you must complete the required "Record Challenge Form", available at: https://bci.utah.gov/criminal-records/criminal-records-forms/, and submit it directly to BCI.

Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of Utah Code § 63G-4-301 and Utah Admin. Code R151-4-902.

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Verification of Active Practice as a Certified Nurse Aide

Applicants for the Medication Aide Certification must demonstrate 2,000 hours of experience as a CNA.
Each employer must complete a separate form.

APPLICANT INFORMATION
(TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Address: _____ City: _____ State: _____ Zip: _____

CNA Registration Number: _____

EMPLOYMENT INFORMATION:
(TO BE COMPLETED BY THE EMPLOYER.)

Name of Health Care Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Dates of Employment: _____ to _____

How many hours did the applicant work per week? _____

Total number of hours practiced as a Certified Nurse Aide: _____

Describe the applicant's duties: *(attach additional form if needed)*

Is the applicant still employed? ☐ Yes ☐ No

The applicant is/was a ☐ W-2 Employee ☐ Contracted Labor.

If no, is the applicant re-hirable? ☐ Yes ☐ No

If Not re-hirable, Please explain:

ATTESTATION:

I do hereby certify that the applicant for licensure as a **Medication Aide Certified** was actively engaged in the lawful practice at the above-named establishment for the number of hours listed.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Authorized Signature: _____ Date: _____

Relationship to Applicant: _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information, which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

All applicants are required to submit following items to complete the application:

- ☐ $80.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either the "Qualifying Questionnaire" or "Medical Qualifying Questionnaire".
- ☐ Fingerprints to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Please see our website, www.dopl.utah.gov/fingerprints.html, for required information and approved locations to obtain fingerprints.
- ☐ Official verification of current certification in good standing as a Certified Nursing Assistant with the Utah Nursing Assistant Registry.
- ☐ Certificate of completion and /or transcripts from an approved Medication Aide Education Program.
- ☐ Verification of 2,000 hours of experience within the two years prior to application, working as a certified nurse aide in a long-term care facility or another health care facility.
- ☐ Letters of recommendation from each of the following who have supervised your work as a CNA:
  - A long-term care facility administrator, *and*
  - a licensed nurse

Submit completed application to the Division:

By US Postal Service:

Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

By in-person or express delivery:

Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84111

If you have questions, please contact the Division at 801-530-6628 or by email at B7@Utah.gov.