

CHECKLIST AND INSTRUCTIONS FOR MEDICATION AIDE REINSTATEMENT

To avoid delays in the processing of this APPLICATION FOR REGISTRATION AS A MEDICATION AIDE BY REINSTATEMENT, follow the instructions carefully before submitting this application. It is important to complete all requirements and send in all required supporting documents as listed below.

AN INDIVIDUAL WHOSE REGISTRATION HAS LAPSED FOR MORE THAN ONE YEAR SHALL COMPLETE:

- APPLICATION** – This application will not be considered until all sections have been completed, including the certification. The applicant may need to submit supporting documentation regarding responses to the licensure questions. This application must be returned to the board by mail. **Faxed, scanned or photocopied applications are not accepted.**
- APPLICATION FEE** – All fees are non-refundable. The fee for application by reinstatement is \$90.00. Make a check or money order payable to the Treasurer of Virginia, and mail it with your application. The application will not be reviewed or considered until payment is submitted.
- CONTINUING EDUCATION** – Submit evidence of completion of all required continuing education for the period since the last renewal (4-hour population specific medication aide training for each year in which the registration has lapsed or a 4-hour or 8-hour refresher course).
- ATTESTATION** – Attest that there are no grounds for denial of registration as specified in §54.1-3007 of the Code of Virginia.
- STATE EXAMINATION** – Pursuant to 18VAC90-60-100 of the Regulations Governing the Registration of Medication Aides, an individual whose registration has lapsed for more than one year shall retake and pass the Virginia Medication Aide Competency Examination. Once the application is complete and has been approved the applicant will receive information and registration materials regarding the state examination.
- SUPPORTING DOCUMENTS (IF APPLICABLE)** –
 - Detailed explanation of conviction(s)** – Detailed explanation should describe the circumstances that caused each conviction; what happened, when it happened, why it happened, and what you have done or are doing to ensure these incidents will not happen again. To avoid delays this information should be included with the application.
 - Certified Court Order(s)** – To avoid delays, contact the court(s) and request a certified copy of the conviction record(s) from the appropriate court clerk's office (either the arrest warrant with the back filled out by the judge (misdemeanor) or the final Sentencing Order if it were a felony for conviction. If the Sentencing Agreement makes mention of a pre-hearing or probationary report, that report must also be included. Certified documents must be **emailed/mailed** to the Virginia Board of Nursing, Attention Medication Aide. **Photocopied or faxed court orders are not accepted.** If court records are no longer available, contact the court(s) and request a certified statement that your records are no longer available. Certified statement must be **emailed/mailed** to the Virginia Board of Nursing.
 - Proof all court ordered requirements have been met** (for example: payment of fines/fees/restitutions/status of an approved payment plan, completion of community service, completion of any treatment programs, and status of probation).

Name Change Document – If **any** of your documentation or supporting documentation (i.e. certificates, supporting documents, court documents) are in a different name from the name provided on your application, include a copy of the legal document that changed your name to the Virginia Board of Nursing, Attention Medication Aide. (Acceptable forms are marriage certificate, divorce decree, certificate of naturalization or court order).

GENERAL INFORMATION ABOUT THE APPLICATION PROCESS

1. Any person administering medications in an assisted living facility during the time a registration has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of §54.1-3008 of the Code of Virginia.
2. Applications received without the required processing fee will be returned to the sender.
3. Faxed or photocopied documents will not be accepted; only original documents will be accepted.
4. Applications are processed in the order received and may take 30-45 business days to review/complete from the initial application date. Board staff will contact you if any additional information is needed. Please allow time (30-45 business days) for a thorough review of all your application documentation before contacting the Board, as it may slow down the review process of your application.
5. Applications will remain on file with the board for one year from the date of receipt. If, at the end of one year, licensure/certification/registration is not issued, the applicant must reapply in accordance with the requirements of the Regulations.

COMPLETED APPLICATIONS AND SUPPORTING DOCUMENTATION SHOULD BE MAILED TO:

ATTN: Medication Aide
Virginia Board of Nursing
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Email: rr-dhpmedicationaide@dhp.virginia.gov



Virginia Department of
Health Professions
Board of Nursing

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
www.dhp.virginia.gov/nursing

Phone (804) 367-4515

FOR OFFICE USE ONLY

File #	Fee	Exam Eligibility Letter Sent	Certificate of Completion
Approved By	Date Passed	Registration Number 0031-	Date Issued

Application for Medication Aide Reinstatement

Complete this application only if your medication aide registration has been lapsed for more than one year.

INCLUDE A \$90 CHECK OR MONEY ORDER MADE PAYABLE TO “TREASURER OF VIRGINIA.”

THIS APPLICATION FEE IS NONREFUNDABLE

A FAXED OR PHOTOCOPIED APPLICATION CANNOT BE ACCEPTED

I hereby make application to reinstate my registration to practice as a Medication Aide in the Commonwealth of Virginia. The following information in support of my application is submitted.

*Disclosure of Address: Some licensees have expressed concern that their residence address is accessible to the public. Consistent with Virginia law, a licensee’s address of record is public information. However, it is permissible for an individual to provide an address of record other than a residence, such as a Post Office Box or a practice location. Changes of address may be made at the time of renewal or at anytime by written notification to the appropriate health regulatory board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

**Disclosure of Social Security/Virginia DMV Number: When completing the application, you are required to submit your social security or a control number issued by the Virginia Department of Motor Vehicles (in accordance with Section 54.1-116 of the Code of Virginia). If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

APPLICANT IDENTIFYING INFORMATION (Print in blue or black ink)

Last Name:	First Name:	Middle Name:	Maiden Name:
Address of Record (Mailing Address):	City:	State:	Zip Code:
Publicly Disclosed Address:	City:	State:	Zip Code:
Social Security Number or Virginia DMV Control Number:	Date of Birth: (MM/DD/YYYY) ____/____/_____		

Email Address:	Telephone Number: ()
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Virginia Medication Aide Registration Number:	Registration Expiration Date: (MM/DD/YYYY)
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Print your name as you wish it to appear on your registration:

Name at the Time of Initial Registration:

If your name has changed since receiving your MOST RECENT registration to practice as a medication aide, you must submit a copy of the state issued marriage certificate or court order authorizing the name change (i.e., divorce decree, certificate of naturalization, etc.) with this application. **Your name will not be changed without proper documentation.**

REINSTATEMENT REQUEST DUE TO: _____ Registration Lapse _____ Registration Suspension or Revocation

MILITARY QUESTIONS:

- A. Are you an active member or veteran of the U.S. military? YES _____ NO _____
- B. Are you a **spouse** of someone who is on federal active-duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one (1) year of submission of this application **and** who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia? YES _____ NO _____

LICENSURE QUESTIONS

1. Can you attest to there being no grounds for denial of your application for reinstatement as specified in §54.1-3007 of the Code of Virginia? YES NO

2. Since the last renewal period, have you completed 4 hours of population specific medication aide training for each year in which the registration has lapsed? YES NO
 If "yes," include the certificate(s) of completion with this application.

3. Since the last renewal period, have you completed a 4-hour or 8-hour refresher course in medication administration offered by a board approved medication aide training program? YES NO
 If "yes," include the certificate of completion with this application.

4. Have you ever been convicted of a violation of /or pled Nolo Contendere to any federal, state or local statute, regulation, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? Including convictions for driving under the influence; excluding traffic violations. YES NO
 If "yes," provide a full explanation, **in detail**, on a separate piece of paper and attach your original criminal history record, a certified copy of any final order, or case decision by a court or regulatory agency, and any other information to be considered with your application (i.e. information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).

5. Have you ever had action taken against or been denied a license or certificate in a health-related field? YES NO
 If "yes," provide a full explanation, **in detail**, on a separate piece of paper and submit notices, orders, etc., from the regulatory authority where disciplined.

6. Within the past five years, have you been disciplined by any entity? **YES** **NO**

If "yes," provide a full explanation, **in detail**, on a separate piece of paper and submit notices, orders, etc., from the entity where disciplined.

7. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? **YES** **NO**

ADDITIONAL LICENSURE QUESTIONS

Respond in full to the following questions. You may provide required details on a separate sheet of paper.

A. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? **YES** **NO**

If yes, provide a full explanation. Note: The Board may ask for additional documentation.

B. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? **YES** **NO**

If no, provide a full explanation. Note: The Board may ask for additional documentation.

C. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? **YES** **NO**

If yes, provide a full explanation. Note: The Board may ask for additional documentation.

D. Within the past five years, have you been disciplined by any entity? **YES** **NO**

If yes, provide a full explanation and any associated orders or letters from the entity

E. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? **YES** **NO**

If yes, provide a full explanation and any associated orders or letters from the entity. (**NOTE:** The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may provide this documentation with your application, or have the program send this documentation directly to the Board.)

EDUCATION

List Each Continuing Education, Training Program or Refresher Course Completed	Number of Education Hours	Date Started	Date Completed	Pass or Fail

CERTIFICATION

I certify by entering my signature below, I am the person applying for licensure and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me and that statements made on the application are true and complete. I understand that providing false or misleading information as well as omitting information in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial or taking disciplinary action against an existing license.

I agree to the above certification.

Signature: (Full Legal Name)

Date: