



**3. VERIFICATION** Check the three (3) boxes that apply.

- A copy of the Medication Aide Training Program Certificate, verifying the nurse aide's successful completion of a Medication Aide Training Program approved by the Wisconsin Department of Health and Family Services.
- This individual has challenged and successfully passed the Wisconsin Medication Aide Competency Examination.
- I affirm that I have reviewed this applicant's records and he/she qualifies for the Nurse Aide Medication Assistant Registry.
- I have documented this person's identity.

**Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**4. MAILING INSTRUCTIONS**

Mail original application and documentation  
to Pearson VUE at:

**Pearson VUE  
PO Box 13785  
Philadelphia, PA 19101-3785**

Mail copy of this form and  
documentation to:

**Department of Health Services  
Pharmacy Practice Consultant  
PO Box 2969  
Madison, WI 53701-2969**