|  |  |
| --- | --- |
| DEPARTMENT OF HEALTH SERVICES Division of Quality Assurance  F-62586 (08/2022) | **STATE OF WISCONSIN** |

**CHALLENGE EXAM APPLICATION FOR NURSE AIDE / MEDICATION AIDE**

### This application reports the successful completion of a Wisconsin approved medication aide training program by a nurse aide previously included on the Registry. Successful completion of the medication aide training program allows a nurse aide to administer medications in a federally certified skilled nursing home.

### The personal information will only be used to determine your nurse aide employment eligibility.

### This application will not be processed if it is incomplete, unsigned or illegible.

### Questions about completion of this form may be directed to 608-225-2528.

### SUBMIT THE FOLLOWING ITEMS WITH THIS APPLICATION:

* Letter of recommendation from DON, Nursing Home Administrator, and two (2) charge nurses.
* Transcripts that document medication administration courses attended (if applicable).
* Certification of Med Aide from another state and criteria to be a Med Aide in that state (if applicable).
* SUBMIT ALL MATERIALS TO: **Division of Quality Assurance**

**ATTN: Pharmacy Consultant**

**P.O. Box 2969**

**Madison, WI 53701-2969  
 Email:** [dhswidqa\_natcep@dhs.wisconsin.gov](mailto:dhswidqa_natcep@dhs.wisconsin.gov)  
 **Fax:** **608-267-0352**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| APPLICANT INFORMATION | | | | | | | | | | |
| Name – Applicant | | | | | | | | Date Application Completed | | |
|  | | | | | | | |  | | |
| Birth Date | Registration Number | Phone Number (Home) | | | Phone Number (Work) | | Email | | | |
|  |  |  | | |  | |  | | | |
| Mailing Address | | | City | | | | | State | | Zip Code |
|  | | |  | | | | |  | |  |
| Name – Employer | | | | | | | | | | |
|  | | | | | | | | | | |
| Address – Employer | | | | | | | | | | |
|  | | | | | | | | | | |
| Preferred Testing Location | | | | | | | | | | |
|  | | | | | | | | | | |
| RELEASE | | | | | | | | | | |
| I authorize or its appointed representative, to release the information on this form to the Wisconsin Nurse Aide Directory. I also authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , or its representative, to release necessary information regarding my performance in the Nurse Aide / Medication Aide course to my current employer or any future prospective employer. | | | | | | | | | | |
| SIGNATURE – Applicant | | | | | | Date Signed | | | | |
| VERIFICATION | | | | | | | | | | |
| I have verified this applicant’s background and have determined that the applicant is:  Eligible  Not Eligible for Challenge Testing.  The applicant is required to participate in the following:  Final Exam  Practicum Exam | | | | | | | | | | |
| **SIGNATURE** – Pharmacy Consultant | | | | Title | | | | | Date Verified | |