APPLICATION FOR ENTRY INTO MEDICINE AIDE TRAINING

This information is required by the Maryland State Department of Licensing and Regulation.

APPLICANT'S NAME: _____ **APPLICANT'S PHONE NUMBER:** _____

CURRENT EMPLOYMENT STATUS

Current Employer _____ Immediate Supervisor _____

Employer's Address _____
(Street) (City) (State) (Zip)

Employer's Telephone # __(_____)_____ Your Job Title _____

Date Hired _____ Current Status: _____ Full-time _____ Part-time

Total Hours Worked _____ (You must have worked a minimum of *2000 hours* (1 year full-time) within the last 3 years to qualify for the medicine aide training. If you have not met the requirement with your present employer, please list previous employment below.)

I hereby certify that the above information is true and correct and that I recommend the above named Geriatric Nursing Assistant for entry into the Medicine Aide course.

_____ _____
Signature of Administrator / Director of Nursing **Date**

PREVIOUS EMPLOYMENT

If you have not met the 2000-hour requirement in your current position, you must:

List the **Maryland** nursing homes and the number of hours you worked there as a geriatric nursing assistant and provide **written documentation of hours worked from the Human Resource department from past employer**. You must have worked a minimum of 2000 hours (1 year full-time) in a Maryland Nursing Home within the last 3 years to qualify for the medicine aide course.

EMPLOYER	EMPLOYMENT DATES	SUPERVISOR	HOURS
		TOTAL HOURS WORKED	_____

I hereby certify to the best of my knowledge that all of the above information is true and correct.

_____ _____
Student's Signature **Date**