NEW LICENSE APPLICATION
BOARD OF NURSING

TRAINED MEDICATION EMPLOYEE (TME) EXAMINATION APPLICATION INSTRUCTIONS

Thank you for submitting an application for certification as a Trained Medication Employee (TME) in the District of Columbia.

GENERAL REQUIREMENTS

Section1. Requested Certificate Type/Fees

Select the application that applies to you:

Examination or Reciprocity

Applicants must meet the following criteria:

Examination

(1). Be18 years of age
(2). Never been convicted of a crime of moral turpitude which bears directly on the applicant's fitness to be certified
(3). Complete a criminal background check
(4). Worked one (1) year of clinical experience in a health care facility
(5). Provide (2) two passport–type photos of the applicant's face, measuring approximately 2"x 2" with the applicant's name and social security number printed on the back. **Home snapshots are not acceptable**
(6). Have documents signed by the Medication Administration Trainer verifying completion of the Trained Medication Employee Course:
•Class Checklist
•Checklist for Administration of Oral Medication
(7). Copy of CPR and First Aid Card
(8). Have completed and signed the application
(9). Application fee ($59.00)

Once a candidate is approved to sit for the examination, they will receive an approval letter advising them to bring a picture (photo I.D.) and the letter to the exam site. No one is allowed in the examination area without the appropriate documents. You have six months to scheduled and take the exam.

Section 2. Applicant's Name/Demographic Information/Race & Ethnicity Designation

Enter your name exactly as it should appear on the certificate. If your name on the application is different from the name on your supporting documentations, provide a copy of a legal name change document. Acceptable documents include a marriage certificate, divorce decree, court order or spouse's death certificate. Race & Ethnicity, check what applies to you.

Section 3(A) (B). Home/Business Address /Training Program

A. Include your home or business addresses in the sections provided. If you use a PO Box, provide a street address if applicable. The zip code should correspond to the PO Box number and the mailing address.
B. Include the school attended, address, and date of completion.

Section 4. Professional Certification in Other Jurisdictions

Complete this area if it applies to you. Indicate the type of certificate.

Section 5. Supporting Documents Required

These are the same required documents listed in the examination/reciprocity area (Section 1).

Section 6. Screening Questions

Please answer all the questions. If you answer "YES" to question 6(A), you must provide from the Tax Office supporting documents indicating you paid the fee or made some type of payment arrangement.

If you answered "YES" to any of the questions (Section 6(B-H)) or have been convicted of a crime and had actions taken against you, please provide a full explanation typed on a separate sheet of paper attached with the application form. In addition, provide official documentation with details regarding the outcome or current status of the case.

***A false or misleading statement is the cause for referral to the Board of Nursing for disciplinary action and possible criminal prosecution pursuant to DC Code 22-2514.**

Section 7. Licensed Affidavit

By signing the application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge.

RECERTIFICATION

Recertification of a trained medication employee is required every two (2) years (expiring on October 30). Certificate holders must renew before the expiration of the current certification. Reminder notices go out in the mail 60 days prior to the expiration of your certification.

***It is important that we have your correct address at all times.**

***Applicants are notified by e-mail, telephone or letter when the board receives incomplete (missing documents) applications.**

***Incomplete applications will close after 120 days.**

***The application and processing fee are non-refundable.**

Government of the District of Columbia
Department of Health – Health Regulation Licensing Administration

TRAINED MEDICATION EMPLOYEE EXAMINATION APPLICATION
BOARD OF NURSING

Please read instructions before completing this form. If you have any questions, call HRLA Customer Service at **1-877/672-2174** Monday through Friday, 8:30 AM to 4:30PM EST.

A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 1. REQUESTED LICENSE TYPE/FEES (includes non-refundable application fee – see instructions)

TME – Trained Medication Employee

Examination $59.00

Total Enclosed **$ _____.00**

CRIMINAL BACKGROUND CHECK:
All applicants are required to undergo a Criminal Background Check.
For payment and to schedule an appointment (Call 1-877-783-4187 or www.L1enrollment.com)

Make check or money order payable to DC Treasurer

MAIL TO:

Board of Nursing
P. O. Box 37802
Washington, DC 20013

HRLA ONLY		
Check $	**Check #**	**Staff**
$ _ _ _ .00		

SECTION 2A. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Note: LEGAL NAME: (Do not use any initials unless they are a part of your name)

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

___/_____/____ _____ - _____ - _____ *
Date of Birth **Social Security Number**

GENDER: ☐ **MALE** ☐ **FEMALE**

Place of Birth: _____
(Provide City and State for US birthplace or Country for foreign place of birth)

*All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your license will not be renewed without a valid SSN. You can download the affidavit form by clicking here or printing a copy at www.hrla.doh.dc.gov

SECTION 2B. OTHER NAMES USED: (Please print clearly)

Enter your legal name exactly as it should appear on the license. If your name on this application is different from the name on your supporting documentation provide a copy of a legal name change document. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

SECTION 2C: RACE & ETHNICITY DESIGNATION:

☐ American Indian/Alaskan Native ☐ Asian/South Asian ☐ Black or African American

☐ Caucasian/White ☐ Hispanic or Latino

☐ Other _____ ☐ Native Hawaiian or other Pacific Islander

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

☐ Spanish ☐ French

☐ German ☐ Arabic

☐ Other _____

Note: Provide a P.O. BOX and a street address if possible

Indicate your preferred mailing address by placing an "X" in the appropriate box. All future mailings go to the address checked.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3A. HOME /BUSINESS ADDRESS

☐ **Home Address or** ☐ **DC Local/Mailing Address**

ADDRESS:_____

(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (**____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

Note: You are statutorily required to notify the DC Board of Nursing in writing of an address change within 30 days. Failure to do may result in your not receiving your license, renewal notice or other official notices and can result in a disciplinary action or a fine.

EMAIL ADDRESS (REQUIRED) : _____ **CELL PHONE:** _____

☐ **Business Address**

ADDRESS:_____

(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (**____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____ **CELL PHONE:** _____

SECTION 3B. TRAINING PROGRAM (MANDATORY)

Program Name, City, State, Country	Address	Date of Completion mm/yyyy

SECTION 5.

Submit the following supporting document with your application. Incomplete applications may be returned

A.	Two 2x2 passport – type photos of the applicant's face with the applicant's name and social security number printed on the back. [Photo copies will not be accepted]	YES ☐ NO ☐	
B.	Letter from employer affirming at least one (1) year of clinical experience in a health care facility.	YES ☐ NO ☐	
C.	Copy of current CPR certificate.	YES ☐ NO ☐	
D.	Copy of first-aid certificate.	YES ☐ NO ☐	
	Clean hands- Attach full information and complete details on a separate sheet of paper, including: Letter from DC Office of Tax and Revenue regarding "Yes" response to question 6A	YES ☐ NO ☐	

	Termination - Attach Relevant court documents, letter from employer, etc., regarding your "Yes" response to questions 6B-H	
E.	**Employer/Trainer attach following to each application package:** Class List signed by Trainer verifying satisfactory completion of TME Course Checklist for Administration of Oral Medications signed by Trainer	YES ☐ NO ☐

SECTION 6. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to the questions below, you must provide full information and complete details **on a separate sheet of paper, including copies of relevant court documents,** and attach to this application

		HRLA ONLY
A. **Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.** Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001). **PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be reissued a license if you have failed to file your District tax returns.** **IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR REINSTATEMENT APPLICATION BE DENIED.** **As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following**: Yes ☐ No ☐ 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).	YES ☐ NO ☐	
B. Have you ever been convicted or arrested for a crime (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☐	☐
C. Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐	☐
D. Have you ever voluntarily surrendered a license/certification after formal charges have been filed against you or while under investigation?	YES ☐ NO ☐	☐
E. Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☐	☐
F. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your vocation?	YES ☐ NO ☐	☐
G. Have you withdrawn an application (in DC or any other state/jurisdiction) to practice your vocation, or are you currently under investigation by any authority for any violation of state, federal, or local law, or has any authority informed you of any pending charges not previously reported to this board?	YES ☐ NO ☐	☐
H. Have you ever been terminated or asked to resign from employment since obtaining your license/certification?	YES ☐ NO ☐	☐

SECTION 7. APPLICANT'S AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT'S SIGNATURE	NAME (Please Print)	DATE	HRLA ONLY
			☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.

IMPORTANT CONTACT INFORMATION

District of Columbia Health Regulation Licensing Administration
899 North Capitol St. N.E.
Washington, DC 20002

Mail: Board of Nursing – P.O. Box 37802, Washington, DC

To check Application Status: www.hrla.doh.dc.gov
HRLA Customer Service: 1-877-672-2174/ www.hrla.doh.dc.gov
Criminal Background Check (CBC) Unite Email doh.cbcu@dc.gov
Board Email: HPLAcomments@dc.gov