GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

NEW LICENSE APPLICATION
BOARD OF NURSING

TRAINED MEDICATION EMPLOYEE (TME) APPLICATION INSTRUCTIONS FOR RECIPROCITY

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

GENERAL REQUIREMENTS

Section1. Certificate Type/Fees

<u>Reciprocity</u>

If you are currently certified as a Medication Aide in MD., VA., or any other state approved by the Board of Nursing you may apply by reciprocity to be a TME in the District of Columbia. If your certification has expired, you are not eligible for reciprocity.

Applicants must meet the following criteria and provide the following documents:

(1) Be18 years of age or greater
(2) Must have been employed in a health care facility and acquired at least one (1) year of clinical experience
(3) Must have a copy of current Trained Medication Aide certification
(4) Must have a copy of current CPR and First Aid Card
(5) Must provide two (2) passport–type photos of the applicant's face, measuring
(6) Must complete a criminal background check (fingerprinting)
(7) Must have completed and signed an application with $59.00 Application fee

Incomplete applications may either be returned or you may be contacted for additional information. An application that remains incomplete after 120 days will close. Should the application be closed, the application fee is non-refundable.

Section 2. Applicant's Name/Demographic Information
Enter your name exactly as it should appear on the certificate and provide the other indicated information. All applicants must provide a Social Security Number (SSN). 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 certification will not be renewed without a valid SSN. You can print a copy of the affidavit form at our website: www.doh.dc.gov/service/health-professionals

Section 2(A). Other Names Used
If your name on the application is different from the name on your supporting documents, you must provide a copy of a legal name change document. Acceptable documents include a marriage certificate, divorce decree, court order or spouse's death certificate.

Section 2(B). Race & Ethnicity Designation/Language(s) Spoken
Race & Ethnicity, check what applies to you. Completion is not mandatory. Use your own discretion.

Section 3. Preferred Mailing Address
This is the address that we will use for all future mailings.

Section 3A. Home/Business Address, Include your home **and**/or business address(es) in the sections provided. If you use a PO Box, also provide a street address. The zip code(s) should correspond to the

address(es) provided. Addresses, email and telephone numbers must be current so that we can contact you when needed.

Section 4. Professional Certification in Other Jurisdiction (State)
Indicate the type of certificate, jurisdiction, status, and certification number.

Section 5. Supporting Documents Required
Check the items on the list **that correspond to the supporting documents you attached.**

(1) Letter from employer affirming at least one (1) year of clinical experience in a health care facility
(2) Copy of current certification from the state you are currently registered with
(3) Copy of current CPR certificate
(4) Copy of current first-aid certificate
(5) Two (2) 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**

Include (if required):

- supporting documents for items in **Section 6. Screening Questions** for which you answered "Yes"
- SSN Affidavit
- Application fee ($59.00)

Section 6. Screening Questions
The Clean Hands Act determines if a person owes the District of Columbia money by requiring the applicant to answer the screening questions. Please answer all the questions. If you answer "YES" to question 6(A), you must provide from the DC Office of Tax and Revenue, Department of Motor Vehicles or any government agency that you owe money to; one of the following supporting documents:

a. Official documents indicating you have an appeal pending
b. Official receipt or letter indicating you met all your obligations and paid the traffic fines or back taxes
c. Official letter indicating you made payment arrangements (payment plan)

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. Applicant's 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 (the odd number -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.

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

TRAINED MEDICATION EMPLOYEE RECIPROCITY 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

RECIPROCITY $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 go online to www.l1enrollment.com)

Make check or money order payable to DC Treasurer

MAIL ALONG WITH APPLICATION TO:

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

SECTION 2. 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 certification will not be renewed without a valid SSN. You can print a copy of the affidavit form at our website: www.doh.dc.gov/service/health-professionals**

SECTION 2A. 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 2B. RACE & ETHNICITY DESIGNATION:

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

☐ **Caucasian/White** ☐ **Hispanic or Latino**

☐ **Native Hawaiian or other Pacific Islander** ☐ **Other** ____________________

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

☐ **Spanish** ☐ **French**

☐ **German** ☐ **Arabic**

☐ **Other** ________________

SECTION 3. PREFERRED MAILING ADDRESS

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 4. PROFESSIONAL CERTIFICATION IN OTHER JURISDICTIONS

MANDATORY FIELD	JURISDICTION	ACTIVE/ NOT ACTIVE	CERTIFICATION NUMBER
Original certification			
Current certification (if certification in original jurisdiction is not active)			

SECTION 5. SUPPORTING DOCUMENTS REQUIRED

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

A.	Letter from employer affirming at least one (1) year of clinical experience in a health care facility	YES ☐ NO ☐
B.	Copy of current certification from the state you are currently registered with	YES ☐ NO ☐
C.	Copy of current CPR certificate.	YES ☐ NO ☐
D.	Copy of first-aid certificate.	YES ☐ NO ☐
E.	Two (2) 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. [Photo copies will not be accepted.]	YES ☐ NO ☐
	If after reading 6A below - Clean hands - **your response to any part is "Yes"** - a separate sheet of paper with full information and complete details including: A status Letter from DC Office of Tax and Revenue **is attached to this application.**	YES ☐ NO ☐
	If after reading 6B-H below - your **response is "Yes"** – a relevant letter of explanation, letter from employer, court documents, etc., is **attached to this application.**	YES ☐ NO ☐

A. **<u>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.</u>** **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).** **<u>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.</u>** **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 ☐

APPLICANT'S SIGNATURE	NAME (Please Print)	DATE

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