GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION

TRAINED MEDICATION EMPLOYEE APPLICATION
BOARD OF NURSING

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at 1-202-442-9200, Monday through Friday, 8:15 AM to 4:45PM 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

☐ Initial Certification $59.00

☐ Reciprocity (Current Certified in another jurisdiction) $59.00

Total Enclosed **$ _____.00**

Make check or money order payable to DC Treasurer.

MAIL TO:
Department of Health
Health Professional Licensing Administration
Board of Nursing
717-14TH Street, NW
Suite 600
Washington, DC 20005

HPLA ONLY		
Check $	Check #	Staff
$ _ _ _ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your legal name exactly as it should appear on the Certificate.

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

SOCIAL SECURITY NUMBER ___ – __ – ____
If applicant does not provide a social security number, a sworn affidavit is required.

DATE OF BIRTH M M – D D – Y Y Y Y

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

GENDER ☐ Male ☐ Female
Please check the correct box.

SECTION 3A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4 ____ – ____

HOME PHONE NUMBER ___ – ___ – ____ HOME FAX NUMBER ___ – ___ – ____ E-MAIL ADDRESS

SECTION 3B. BUSINESS ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

AGENCY'S NAME

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE

ZIP CODE + 4

BUSINESS PHONE NUMBER

BUSINESS FAX NUMBER

E-MAIL ADDRESS

SECTION 4. PREFERRED MAILING ADDRESS

This will be the address to which all future documents will be mailed.

☐ HOME ☐ BUSINESS

SECTION 5. SUPPORTING DOCUMENTS REQUIRED

Please <u>submit all</u> of the following supporting documents along with your application. <u>Incomplete applications will be returned.</u>

			HPLA ONLY
A.	Two 2x2 passport – type photos of the applicant's face with the applicant's name and social security number printed on the back.	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 ☐	☐
E.	Documentation signed by Trainer verifying satisfactory completion of TME Course	YES ☐ NO ☐	☐
F.	**Reciprocity applicants only** Evidence of current certification from MD, VA, or any other state approved by the Board	YES ☐ NO ☐	☐

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

Please answer all of the following questions. If you answer 'Yes' to any of the questions B through F below, you must provide full information and complete details on the text area below the question.

		HPLA 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 can not 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	HPLA ONLY
			☐

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