Virginia Department of Health Professions
Board of Nursing

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
www.dhp.virginia.gov/nursing

Phone (804) 367-4515
Fax (804) 527-4455

CHECKLIST AND INSTRUCTIONS FOR MEDICATION AIDE REINSTATEMENT

To avoid delays in the processing of this APPLICATION FOR REGISTRATION AS A MEDICATION AIDE BY REINSTATEMENT, follow the instructions carefully before submitting this application. It is important to complete all requirements and send in all required supporting documents as listed below.

AN INDIVIDUAL WHOSE REGISTRATION HAS LAPSED FOR MORE THAN ONE YEAR SHALL COMPLETE:

☐ **APPLICATION** – This application will not be considered until all sections have been completed, including the certification. The applicant may need to submit supporting documentation regarding responses to the licensure questions. This application must be returned to the board by mail. **Faxed, scanned or photocopied applications are not accepted.**

☐ **APPLICATION FEE** – All fees are non-refundable. The fee for application by reinstatement is $90.00. Make a check or money order payable to the Treasurer of Virginia, and mail it with your application. The application will not be reviewed or considered until payment is submitted.

☐ **CONTINUING EDUCATION** – Submit evidence of completion of all required continuing education for the period since the last renewal (4-hour population specific medication aide training for each year in which the registration has lapsed or a 4-hour or 8-hour refresher course).

☐ **ATTESTATION** – Attest that there are no grounds for denial of registration as specified in §54.1-3007 of the Code of Virginia.

☐ **STATE EXAMINATION** – Pursuant to 18VAC90-60-100 of the Regulations Governing the Registration of Medication Aides, an individual whose registration has lapsed for more than one year shall retake and pass the Virginia Medication Aide Competency Examination. Once the application is complete and has been approved the applicant will receive information and registration materials regarding the state examination.

☐ **SUPPORTING DOCUMENTS (IF APPLICABLE)** –

☐ **Detailed explanation of conviction(s) –** Detailed explanation should describe the circumstances that caused each conviction; what happened, when it happened, why it happened, and what you have done or are doing to ensure these incidents will not happen again. To avoid delays this information should be included with the application.

☐ **Certified Court Order(s)** – To avoid delays, contact the court(s) and request a certified copy of the conviction record(s) from the appropriate court clerk's office (either the arrest warrant with the back filled out by the judge (misdemeanor) or the final Sentencing Order if it were a felony for conviction. If the Sentencing Agreement makes mention of a pre-hearing or probationary report, that report must also be included. Certified documents must be **mailed** to the Virginia Board of Nursing, Attention Medication Aide. **Photocopied or faxed court orders are not accepted.** If court records are no longer available, contact the court(s) and request a certified statement that your records are no longer available. Certified statement must be **mailed** to the Virginia Board of Nursing.

☐ **Proof all court ordered requirements have been met** (for example: payment of fines/fees/restitutions/status of an approved payment plan, completion of community service, completion of any treatment programs, and status of probation).

☐**Name Change Document** – If **any** of your documentation or supporting documentation (i.e. certificates, supporting documents, court documents) are in a different name from the name provided on your application, include a copy of the legal document that changed your name to the Virginia Board of Nursing, Attention Medication Aide. (Acceptable forms are marriage certificate, divorce decree, certificate of naturalization or court order).

GENERAL INFORMATION ABOUT THE APPLICATION PROCESS

1. Any person administering medications in an assisted living facility during the time a registration has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of §54.1-3008 of the Code of Virginia.
2. Applications received without the required processing fee will be returned to the sender.
3. Faxed or photocopied documents will not be accepted; only original documents will be accepted.
4. Applications are processed in the order received and may take 30-45 business days to review/complete from the initial application date. Board staff will contact you if any additional information is needed. Please allow time (30-45 business days) for a thorough review of all your application documentation before contacting the Board, as it may slow down the review process of your application.
5. Applications will remain on file with the board for one year from the date of receipt. If, at the end of one year, licensure/certification/registration is not issued, the applicant must reapply in accordance with the requirements of the Regulations.

COMPLETED APPLICATIONS AND SUPPORTING DOCUMENATION SHOULD BE MAILED TO:

ATTN: Medication Aide
Virginia Board of Nursing
9960 Mayland Drive, Suite 300
Henrico, VA 23233

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Board of Nursing

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FOR OFFICE USE ONLY			
File #	Fee	Exam Eligibility Letter Sent	Certificate of Completion
Approved By	Date Passed	Registration Number 0031-	Date Issued

Application for Medication Aide Reinstatement

Complete this application only if your medication aide registration has been lapsed for more than one year.

INCLUDE A $90 CHECK OR MONEY ORDER MADE PAYABLE TO "TREASURER OF VIRGINIA."
THIS APPLICATION FEE IS NONREFUNDABLE
A FAXED OR PHOTOCOPIED APPLICATION CANNOT BE ACCEPTED

I hereby make application to reinstate my registration to practice as a Medication Aide in the Commonwealth of Virginia. The following information in support of my application is submitted.

*Disclosure of Address: Some licensees have expressed concern that their residence address is accessible to the public. Consistent with Virginia law, a licensee's address of record is public information. However, it is permissible for an individual to provide an address of record other than a residence, such as a Post Office Box or a practice location. Changes of address may be made at the time of renewal or at anytime by written notification to the appropriate health regulatory board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

**Disclosure of Social Security/Virginia DMV Number: When completing the application, you are required to submit your social security or a control number issued by the Virginia Department of Motor Vehicles (in accordance with Section 54.1-116 of the Code of Virginia). If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

APPLICANT IDENTIFYING INFORMATION (Print in blue or black ink)

Last Name:	First Name:	Middle Name:	Maiden Name:
Address of Record (Mailing Address):	City:	State:	Zip Code:
Publicly Disclosed Address:	City:	State:	Zip Code:
Social Security Number or Virginia DMV Control Number:		Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	
Email Address:		Telephone Number: ( )	

Virginia Medication Aide Registration Number:	Registration Expiration Date: (MM/DD/YYYY)
Print your name as you wish it to appear on your registration:	
Name at the Time of Initial Registration:	
If your name has changed since receiving your MOST RECENT registration to practice as a medication aide, you must submit a copy of the state issued marriage certificate or court order authorizing the name change (i.e., divorce decree, certificate of naturalization, etc.) with this application. **Your name will not be changed without proper documentation.**	
REINSTATEMENT REQUEST DUE TO: ☐ Registration Lapse ☐ Registration Suspension or Revocation	

MILITARY SERVICE	**YES**	**NO**
1. Are you active-duty military?	☐	☐
2. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia?	☐	☐

LICENSURE QUESTIONS	**YES**	**NO**
3. Can you attest to there being no grounds for denial of your application for reinstatement as specified in §54.1-3007 of the Code of Virginia?	☐	☐
4. Since the last renewal period, have you completed 4 hours of population specific medication aide training for each year in which the registration has lapsed? If "yes," include the certificate(s) of completion with this application.	☐	☐
5. Since the last renewal period, have you completed a 4-hour or 8-hour refresher course in medication administration offered by a board approved medication aide training program? If "yes," include the certificate of completion with this application.	☐	☐

EDUCATION

List Each Continuing Education, Training Program or Refresher Course Completed	Number of Education Hours	Date Started	Date Completed	Pass or Fail

ADDITIONAL LICENSURE QUESTIONS	YES	NO
6. Have you ever been convicted of a violation of /or pled Nolo Contendere to any federal, state or local statute, regulation, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? Including convictions for driving under the influence; excluding traffic violations. If "yes," provide a full explanation, **in detail**, on a separate piece of paper and attach your original criminal history record, a certified copy of any final order, or case decision by a court or regulatory agency, and any other information to be considered with your application (i.e. information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).	☐	☐
7. Have you ever had action taken against or been denied a license or certificate in a health-related field? If "yes," provide a full explanation, **in detail,** on a separate piece of paper and submit notices, orders, etc., from the regulatory authority where disciplined.	☐	☐
8. Within the past five years, have you been disciplined by any entity? If "yes," provide a full explanation, **in detail,** on a separate piece of paper and submit notices, orders, etc., from the entity where disciplined.	☐	☐
9. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If "yes," provide a full explanation, **in detail,** on a separate piece of paper.	☐	☐
10. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?	☐	☐
11. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Registered Medication Aide. If "yes," provide a full explanation, **in detail,** on a separate piece of paper. **NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.	☐	☐
12. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?	☐	☐
13. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Registered Medication Aide. If "yes," provide a full explanation, **in detail,** on a separate piece of paper. **NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice.	☐	☐
14. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Registered Medication Aide. If "yes," provide a full explanation on a separate piece of paper. **NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.	☐	☐

CERTIFICATION

I certify by entering my signature below, I am the person applying for licensure and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me and that statements made on the application are true and complete. I understand that providing false or misleading information as well as omitting information in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial or taking disciplinary action against an existing license.
☐ **I agree to the above certification.**
Signature: (Full Legal Name)
Date: