Medication Aide Program Checklist

- ☐ Fingerprints must be submitted through the Department of Public Safety's vendor. Once you have submitted your Medication Aide Program Application through TULIP you will receive notification on what steps to take.
- ☐ Form 5523: Experience Document
- ☐ Form 5534: General Statement Enrollment
- ☐ Current Shot Records as required by the Department of State Health Services at the time of enrollment MMR (2); Tetanus (<10 years); Varicella (2); and Hepatitis B Series (2 of 3 doses – must be completed)
- ☐ Certified copy of high school diploma/transcript or high school equivalency; or certified transcript from college or university with credit classes.

All of these requirements must be complete to be approved to register for the Vernon College Medication Aide Program. If any of these items are not returned and/or completed, you will not be approved to take the course. Once you have completed the entire packet, have your shot records, and transcript(s) contact Alanna Lee to schedule an appointment to submit all documents.

Alanna Lee, Coordinator of CE Allied Health

Phone #: (940) 696-8752 Ext. 3361
E-mail: ce@vernoncollege.edu

Packet DUE by 12:00PM August 22, 2025

Registration & Payment DUE by 5:00 PM on August 28, 2025

TEXAS Health and Human Services

Form 5523
June 2024

Medication Aide Program

Medication Aide Experience Documentation Report

1. Applicant Name (last, first, middle initial)		2. Social Security No.	
3. Place of Employment			
4. Employer's Address (Street or P.O. Box)	5. City	6. State	7. ZIP Code
9. Employer's Area Code and Phone No.	9. Type of Facility		
10. Applicant Job Title	11. Type of Work Performed	12. Nurse Aide Certification No. (if Applicable)	
13. Facility Administrator, Program Director, or Director Of Nursing Printed Name			

I certify that the person named above is or was employed by me from {date} (mm/dd/yyyy) to {date} (mm/dd/yyyy).

I know of my own knowledge that this person was continuously employed in this facility as a certified nurse aide under Health and Safety Code Chapter 242, in this licensed personal care facility under Health and Safety Code Chapter 247, or in this state supported living center, Intermediate Care Facilities for Individuals with an Intellectual Disability as an unlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

I certify under penalty of perjury that the information submitted is true and correct.

_____ _____

Signature — Facility Administrator, Program Director, or Director of Nursing **Facility Vendor No.**

Sworn and subscribed to me on this _____ day of _____, 20____ in _____ county, in the state of _____.

Place Notary Seal or Stamp Here

_____
Signature — Notary

_____
Printed Name — Notary

_____
Commission Expiration Date

TEXAS Health and Human Services

Form 5534
June 2024

Medication Aide Program

General Statement of Enrollment

All required forms must be completed and returned in the applicant's TULIP account **no later than 20 days** after the date of the first scheduled class where you are enrolled.

The application cannot be processed if any portion of the form is incomplete, fee is not included or documentation is missing.

Section 1 – Medication Aide completes this application.

Read the following instructions before completing.

- Complete all information in Section 1 and sign to verify the information provided is correct.
- Applicant must sign and date in front of a notary.
- Form must be submitted to your TULIP account by creating the Initial Medication Aide application at Texas Unified Licensure Information Portal.

1. Name (Last, First, MI)	2. Social Security No.		
3. Email Address	4. Home Area Code and Phone No.		
5. Mailing Address (Street or P.O. Box)	City	State	ZIP Code
6. Date of Birth (mm/dd/yyyy)	7. Name of Approved Training School		
8. Mailing Address of Approved Training School (Street or P.O. Box)	City	State	ZIP Code

9. Submit Form 5523, Medication Aide Experience Documentation Report. It documents 90 days of employment in an assisted living facility licensed under Health and Safety Code 247, state supported living center or Intermediate Care Facility for Individuals with and Intellectual Disability as unlicensed direct care staff. This employment must be completed within the 12-month period before the first official class date. **An applicant employed as a certified nurse aide is exempt from the 90-day requirement.**

10. Submit a notarized photocopy as a true copy of an unaltered original of a high school graduation diploma or transcript or a general equivalency diploma. A foreign education evaluation agency must evaluate all foreign education diplomas.

11. All applicants must request a fingerprint-based criminal history check from the Texas Department of Public Safety (DPS) before HHSC can approve your application for examination. Visit Texas Department of Public Safety (DPS) for instructions on how a person can get a fingerprint based criminal history check, or call Fingerprint Applicant Services of Texas (FAST) at 888-467-2080. To get the service code, email the Medication Aide Program. Failure to complete a fingerprint criminal history check will delay the process and may result in denial.

12. Date of First Scheduled Class of Instruction (mm/dd/yyyy):

13. Are you able to read, write, speak and understand English? ◯ Yes ◯ No

14. Are you at least 18 years old? ◯ Yes ◯ No

15. Are you, to the best of your knowledge, free of contagious diseases and in suitable physical and emotional health to safely administer medications? ◯ Yes ◯ No

16. Are you listed on the Employee Misconduct Registry (EMR) as unemployable? ◯ Yes ◯ No

17. Have you been convicted of a criminal offence listed in Texas Health and Safety Code Section 250.006? ◯ Yes ◯ No

If yes, list date _____ and conviction _____

18. Have you received a copy of the Medication Aide Training Program Rules? ◯ Yes ◯ No

If no, get a copy from the training program or call this office.

With few exceptions, you have the right to request and be informed about the information that THHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask THHSC to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004) To find out about your information and your right to request correction, please contact this office.

Read Carefully

When applying to the HHSC Medication Aide Program for a permit as a Medication Aide, I have read and agree to abide by the Medication Aide Training Program rules. I also agree to complete all application requirements and take all examinations necessary to process my application. When a permit is issued, I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (TAC 557.105). I further understand the materials submitted for consideration become department property and are nonreturnable. I am aware of the schedule of fees in TAC 557.109(c) and understand that additional fees must be paid to keep the permit current.

I further agree that if issued a permit, upon the denial, suspension, or revocation of that permit, I shall return the permit to the department. The information I have provided in this application is truthful. I understand that to falsify any information submitted to HHSC may result in voiding this application, failure to be granted a permit or the revocation of my permit.

_____ _____

Signature of Applicant **Date**

Section 2 – Notary Signature

Notary completes this section. Notarize applicant signature at the bottom of this section and return to applicant.

The State of _____

County of _____

Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledged that he or she had executed the same for the purposes and consideration therein expressed and the foregoing statements are true and correct.

Given under my hand seal of office, this ____ day of _____, 20____

Notary Public in and for _____ County, Texas or _____

_____

Signature — Notary

Place Notary Seal
or Stamp Here

_____

Printed Name — Notary

_____

Commission Expiration Date

Submit by mail:

Medication Aide Program
P. O. Box 149030
Mail Code E-416 Austin, TX 78714-9030

With a few exceptions, you have the right to request and be informed about the information that HHSC gets about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, contact the Long-Term Care Regulatory Medication Aide Program at 512-438-2025.