

MINNESOTA STATE COMMUNITY AND TECHNICAL COLLEGE
NORTH DAKOTA MEDICATION ASSISTANT II
APPLICATION QUESTIONNAIRE

The North Dakota Department of Health is requesting you answer these questions prior to the start of the Medication Assistant II course. These questions are also part of the initial Medication Assistant II application form. Complete this questionnaire and return it along with your registration form and payment method to our office where it will be kept on file. @ e questions, M State will forward this form to the ND Department of Health for review, prior to your admittance to the Medication Assistant II program.

PLEASE PRINT

Name _____ CNA Registry # _____

Address _____

City, State, Zip Code _____

Facility _____

ALL QUESTIONS MUST BE COMPLETED BY THE APPLICANT

1.	Have you ever been arrested, charged, or convicted of a felony (<i>You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action</i>) within the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Have you been investigated or are you presently being investigated by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you been denied registration or licensure by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICATION CERTIFICATION: I certify the information provided is true, correct, and complete.

Student Signature

Date

Please return this form to:

M State
Attn: Denice Brewer
1900 28th Ave. So.
Moorhead, MN 56560
Email: denice.brewer@minnesota.edu
Fax: (218) 846-3705

For questions: (218) 299-6576 or (800) 426-