Medication Aide Employment Verification
(Optional form – For Facility Use)
(NC G.S. § 131D-4.5B)

Instructions: Administrator of the facility listed as employer in Section #2 must verify work of individual named in Section # 1 and ensure Sections # 1 through 4 are complete.

This form may be used only for an individual who worked as a Medication Aide**:

- Between 10/01/2011 through 09/30/2013, **and**
- Worked within the 24-month period since 10/01/2013 and every subsequent 24-month period; **and**,
- Passed the written medication exam for adult care homes **prior to 10/01/2013**.

All other individuals must successfully complete the required Medication Aide curriculum training(s). Multiple forms may be necessary if different employers.

Current or Hiring Employer completes Section #5. Questions? Call 919-855-3765.

1. Medication Aide Information

Name of individual requesting verification: _____
(First Name, Middle Initial, Last Name)

SSN – last 4 digits: ___ ___ ___ ___

2. Employer Information providing Verification

a. Facility Name _____ Phone (_____) _____

Facility Address _____

City_____ State _____ Zip_____

b. NC DHSR Facility License Number
(see http://www.ncdhhs.gov/dhsr/reports.htm)

FCL __ __ __ __ __ __
HAL __ __ __ __ __ __
No. (6 digits, omit dashes)

3. Verification of Work

Most Recent Date of work as a Medication Aide* at the facility listed in Section #2.

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2011-09/30/2013)

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2013-09/30/2015)

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2015-09/30/2017)

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2017-09/30/2019)

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2019-09/30/2021)

Date of Qualified Work: **Month** _____ **Day**____ **Year** _____ (Between 10/01/2021-09/30/2023)

Original form must be maintained in the hiring facility record and made available to state and county regulators upon request.

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4. Approving Administrator Signature

Administrator Responsibility: *Ensure dates and employment information is accurate. All reported information is subject to verification with the issuing source. False or incorrect information provided by licensed individuals may be reported to appropriate licensing authorities.* *****The employment as a Medication Aide at the facility of employment identified in Section # 2 qualifies if the individual administered medications only after validation of competency to perform tasks.***

Before you sign:

- Complete all of Section #1 and #2.
- Section #3, verify and fill in the most recent date of work as a Medication Aide.
- Administrator's Signature must be that of the administrator who can verify work as a Medication Aide occurred and the work dates, based on employer records.
- **The Administrator's signature ONLY VERIFIES WORK PERFORMED, NOT COMPETENCY.**

All fields are required and must be completed in ink

Adm. Printed Name: _____ Date: _____

Adm. Original Signature: _____

Certified Adm. Certificate # (if applicable): _____

Phone (if different from above): _____

5. Employing Facility

Verification of Medication Aide taking medication exam**: Pass** ___ **Fail** ___

Date exam taken**: Month** _____ **Day**____ **Year** _____

The individual must have passed the medication exam for adult care homes prior to 10/01/2013, in order to be exempt from completing the required medication aide training for adult care homes.

(Documentation obtained for verification of the medication exam for Adult Care Homes is ONLY via website N.C. Adult Care Testing Website and must be attached).

Note: The current or hiring facility is responsible to ensure staff's competency for any medication tasks or skills that will be performed in the facility.

Original form must be maintained in the hiring facility record and made available to state and county regulators upon request.