MONTANA BOARD OF NURSING
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ASSISTED LIVING MEDICATION AIDE I PROGRAM APPROVAL APPLICATION

(No Fee)

CONTACT PERSON:_____

PHONE NUMBER:_____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PROGRAM TITLE: _____

PROGRAM INSTRUCTOR(S) (must be approved by the Board of Nursing):

_____

_____

Total hours of instruction time:

Total hours of didactic classroom presentation is at least 32 hours minimum: ◯ Yes ◯ No

Total hours of simulated practical experience is at least 8 hours minimum: ◯ Yes ◯ No

Total hours of direct, supervised, clinical experience is at least 40 hours minimum: ◯ Yes ◯ No

Instructor to student ratio for:

Clinical Laboratory setting is a maximum ratio of 1:10: ◯ Yes ◯ No

Clinical Practice setting is a maximum ratio of 1:5: ◯ Yes ◯ No

The following mandatory components are included in this program:

- ☐ The six rights of medication administration
- ☐ Classes of medications
- ☐ Care, storage and regulation of controlled substances and medications
- ☐ Medication log
- ☐ Medication error reporting
- ☐ How and when to report to the supervising nurse
- ☐ Purposes of medications
- ☐ Allowable routes of administration of medications
- ☐ How to administer medications
- ☐ Adverse reactions, side effects and allergies to medications
- ☐ Documentation
- ☐ Complete skills checklist

Signature:_____ Date: _____