MONTANA BOARD OF NURSING
PO Box 200513 (301 S Park, 4th Floor)
Helena, MT 59620-0513
PHONE: (406) 841-2380 EMAIL: nurse@mt.gov
WEBSITE: www.nurse.mt.gov

INSTRUCTIONS FOR MEDICATION AIDE I INSTRUCTORS:

☐ **LICENSURE REQUIREMENTS:** (See rule 24.159.901 and 24.159.905)

- Must have an unencumbered Montana Nurse license.
- Must have at least 2 years of nursing experience in the last 5 years, 1 year of which shall be in a long-term care or home health, hospice, assisted living, or other community based setting; OR be a state certified nursing assistant instructor.
- Must have a working knowledge of assisted living facility rules and regulations.
- It is critical to your application approval not withhold any information regarding each question on the application.

☐ **NON-ROUTINE APPLICATIONS:** (see ARM 24.159.403)

- If the completed application is non-routine, there may be a delay in processing.
- The Board may request that you provide additional information, and you may be requested to make a personal appearance before the Board during a regularly scheduled board meeting.

☐ **IMPORTANT INFORMATION FOR ALL APPLICANTS:**

- The applicant will be notified of any deficiencies in their application.
- When the application is complete, it will be processed and considered by Board staff for permanent licensure.
- It is the responsibility of the applicant to keep the board office informed of any name changes, address changes, changes in licensure status, complaints or proposed disciplinary action against you in this or any other state. The change of address form is available at www.nurse.mt.gov, under the Forms tab.

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

When the Board has all necessary documentation, your application will be processed.
Incomplete applications expire 12 months from the date received by the Board of Nursing.

APPLICATION FOLLOWS

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Application for Licensure as: **Medication Aide I Instructor** (No fee)

Allow 10 business days from the date the Board office has received all required documentation for processing a routine application.

If your application is accepted, your name and contact information will appear on the MT Board of Nursing Website (www.nurse.mt.gov) under the Education Tab, Medication Aide I Education, Approved Medication Aide I Instructors.

PLEASE PRINT OR TYPE

1. FULL NAME: _____
   First Middle Last
2. SOCIAL SECURITY NUMBER: _____
3. OTHER NAME(S) KNOWN BY (i.e. maiden name):_____
4. EMAIL ADDRESS:_____
   (Email is the Board's primary method of communication)
5. DATE OF BIRTH: _____ PLACE OF BIRTH: _____
6. GENDER: ◯ Female ◯ Male
7. MAILING ADDRESS: _____

   City _____ State _____ Zip Code _____

   MAILING ADDRESS IS: ◯ Home ◯ Business
8. TELEPHONE Home: _____ Mobile:_____
9. MONTANA NURSING LICENSE NUMBER:_____
10. LAST 5 YEARS OF EMPLOYEMENT HISTORY:

Name of Facility	Type of Facility	Dates of Employment

11. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

12. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

13. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ◯ Yes ◯ No

14. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

15. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

16. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. ◯ Yes ◯ No

17. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fine of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. ◯ Yes ◯ No

18. Have you ever been diagnosed with substance use disorder or another addiction, or have you participated in an addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ◯ Yes ◯ No

19. Have you been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ◯ Yes ◯ No

20. Have you ever been courts martial or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. ◯ Yes ◯ No

21. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

22. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

23. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc.)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

24. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

25. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

26. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

27. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc.) If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

DECLARATION

I authorize the release of information concerning my education, training record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Nursing. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant_____ Date_____

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ASSISTED LIVING MEDICATION AIDE I PROGRAM INSTRUCTOR APPLICATION ADDENDUM

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE:_____

MONTANA NURSE LICENSE #:_____

1. I hereby certify that my Montana Nursing license is unencumbered. ◯ Yes ◯ No

AND

2. I hereby certify that I have working knowledge of Assisted Living Facility rules and regulations. ◯ Yes ◯ No

AND

3. I hereby certify that I have at least 2 years of Nursing experience in the last 5 years, of which 1 year was in a long-term care, home health, hospice, assisted living or other community based setting. ◯ Yes ◯ No

OR

I hereby certify that I am a state Certified Nursing Assistant Instructor and the above statement does not apply (the first sentence under question 3). ◯ Yes ◯ No

I hereby certify that the information supplied on this addendum is true and correct.

_____ _____
Signature Date

REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states that do not provide verification through NURSYS. Complete the form and mail it to any state board in which you are requesting official license verification be sent to the Montana Board of Nursing. You may make as many copies of this form as you wish. Be advised that some boards require a fee for this service. It is recommended you contact the board(s) prior to mailing in this form to see if you need to include payment. See www.ncsbn.org to find contact information for each board jurisdiction.

LICENSEE INFORMATION

To Whom It May Concern:
I am applying for a license to practice Nursing in the State of Montana and the Nursing Board requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Board of Nursing
PO Box 200513
Helena, MT 59620-0513
Or
Email at: nurse@mt.gov

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____
Street or PO Box #

_____
City State Zip

My License Number from your State is: _____ License Type: _____
