

**Medication Aide Application  
Nursing Graduates and Nursing Students**

Application to be completed by a graduate of an accredited school of nursing or a person attending or who has attended an accredited school of nursing and who does not hold a license to practice professional or vocational nursing, provided the date of graduation or attendance is no earlier than January 1 of the year immediately preceding the year of application for a permit. Refer to Texas Administrative Code, Chapter 95.107 (c) and (d).

**Mail** application and \$25 non-refundable application fee, payable to the Department of Aging and Disability Services, to:  
**Medication Aide Program, P.O. Box 149030, Mail Code E-416, Austin, Texas 78714-9030**

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

1. Name (last, first, middle initial)			2. Social Security No.	
3. Mailing Address (Street or P.O. Box)			4. Home Telephone No. (       )	
City	State	ZIP Code	5. Date of Birth (mm/dd/yyyy)	
6. Name of Accredited School of Nursing				
Address (Street or P.O. Box)		City	State	ZIP Code

7. Indicate method of application (check one)

A. Graduate of an accredited school of nursing:

Date of Graduation (mm/dd/yyyy): \_\_\_\_\_ Submit an official transcript documenting graduation.

Do you have a license to practice professional or vocational nursing? .....  Yes  No

Do you have a temporary permit to practice professional or vocational nursing? .....  Yes  No

Expiration date of license/temporary permit (mm/dd/yyyy): ..... \_\_\_\_\_

Name of the state and board from which license/temporary permit was issued: ..... \_\_\_\_\_

B. Current or former student of an accredited school of nursing:

Date of attendance (mm/dd/yyyy): **From:** \_\_\_\_\_ **To:** \_\_\_\_\_

- Submit an official transcript documenting classes taken.
- Complete Form 5503-MA, Verification of Curriculum, to be submitted to the accredited school of nursing for verification that courses taken cover the department's Medication Aide Training Program curriculum.

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

9. Are you at least 18 years old? .....  Yes  No

10. Are you currently employed in a nursing facility in the capacity of a nurse aide or in an intellectual disability facility as a non-licensed direct care staff person? .....  Yes  No

Name of Facility: \_\_\_\_\_

11. Submit a certified copy (or photocopy that has been notarized as true and exact) of an unaltered original high school diploma or an equivalent GED diploma.

12. 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

13. Have you ever been convicted of a felony or misdemeanor? .....  Yes  No

If yes, provide the following information:

Date of Conviction:..... \_\_\_\_\_

Where Convicted: ..... \_\_\_\_\_

Charge: ..... \_\_\_\_\_

If conviction was set aside, give date and explain, using additional pages if necessary. \_\_\_\_\_

\_\_\_\_\_

**Please Read Carefully**

In making application to the Texas Department of Aging and Disability Services Medication Aide Program for the issuance of 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 for the processing of my application. Upon issuance of a permit, I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (TAC 95.105). I further understand that the materials submitted for consideration become the property of the department and are non-returnable. I am aware of the schedule of fees (TAC 95.109(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 that I have provided in this application is truthful. I understand that to falsify any information submitted to the Texas Department of Aging and Disability Services may result in voiding of this application, failure to be granted a permit or the revocation of my permit.

\_\_\_\_\_  
Signature — Applicant \_\_\_\_\_  
Date

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/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

**Medication Aide Program**  
P. O. Box 149030  
Mail Code E-416  
Austin, Texas 78714-9030  
E-mail Address: [credential@dads.state.tx.us](mailto:credential@dads.state.tx.us)

With a few exceptions, you have the right to request and be informed about the information that the Department of Aging and Disability Services (DADS) obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask DADS 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 the Long Term Care Regulatory Medication Aide Program at 512-438-2025.