Reset Form

QUALIFIED MEDICATION AIDE (QMA) RECORD OF ANNUAL INSERVICE TRAINING

State Form 51654 (R4 / 1-20)
INDIANA STATE DEPARTMENT OF HEALTH – DIVISION OF HEALTH CARE QUALITY & EDUCATION

INSTRUCTIONS:
1. *Please print or write clearly.*
2. *Six (6) hours of inservice training must be completed each year (January – December).*
3. *Only inservices related to medications, medication administration, QMA Scope of Practice, and insulin administration should be included on this form.*
4. *QMA **MUST** keep the original form.*

Name *(Last, First, Middle Initial)*		QMA Certification Number	
Address *(number and street)*	City	State	ZIP code
Telephone *(including area code)*	E-mail address		

Date *(mm/dd/yy)*	Topic *(Medication, Medication Administration and QMA Scope of Practice ONLY)*	Instructor Signature / Credentials	Length *(1/4 Hour Increments)*	ISDH Use Only
		TOTAL HOURS		

QMA Signature: _____ Date *(mm/dd/yy)*: _____