



INITIAL MEDICATION ASSISTANT III APPLICATION
 NORTH DAKOTA BOARD OF NURSING
 SFN 50128 (05-21)

FOR OFFICE USE ONLY	
Fee Received	CHRC Form & fee
Discipline Review	DRP
Approval	Temp Permit Issued
Permanent Issue Date	Registry Number

If an Unlicensed Assistive Person or Medication Assistant had previously been on the UAP/MA Registry, **they must renew/reactivate that registry status prior to hire date including orientation.** Employment prior to renewal/reactivation may be subject to disciplinary action including penalty fees.

APPLICANT INFORMATION (PLEASE PRINT)

First Name		Middle Name		Last Name	
*Social Security Number				Maiden Name	
Mailing Address				City	State
				ZIP Code	
Date of Birth		Home Telephone Number		Work Telephone Number	
Mother's Maiden Name		Email Address		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnic Information <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White-Not of Hispanic Origin <input type="checkbox"/> Asian Indian <input type="checkbox"/> Native American <input type="checkbox"/> Asian Other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other					

*In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to North Dakota Century Code 43-50-02. The individual's social security number is used for identification purposes. Failure to provide the social security number will cause the application to not be processed.

CHOOSE NUMBER ONE OR TWO OF THE FOLLOWING TO COMPLETE:

1. Medical Assistant Program

You must submit the following along with this form and fee:

- a. Complete the following and include a copy of your certification from AAMA, NHA or NCCT; OR Registration from AMT

Name of Certifying Organization	State you obtained your original certification
Certificate Number	Expiration Date

- b. Official Transcript sent directly from school – *Contact your school and have them send official transcripts directly to our office. Only official transcripts sent directly from the school to the Board office are accepted. If your school is closed, it is your responsibility to locate the custodian of the school records. See electronic transcript submission option in Instructions on page 3.*

Name of Medical Assistant Program			
Address		City	State
		ZIP Code	
Date of Enrollment		Date of Completion/Graduation	

2. Nursing Education Program

You must submit the following along with this form and fee:

- a. "Verification of Eligibility for Medication Assistant Registry" form
 (You may find the Verification of Eligibility for Medication Assistant Registry form on our website at www.ndbon.org -choose UAP/MAIII; Overview and Initial Applications; look under Related Information on this page)

Name of Nursing Education Program			
Address		City	State
		ZIP Code	
Date of Enrollment		Approximate Date of Graduation	

CRIMINAL HISTORY RECORD CHECK (CHRC)

1. Have you completed a Criminal History Record Check for the ND Board of Nursing in the past 180 days? <i>Note- the ND Board of Nursing cannot share or receive CHRC results you may have done for other employers, schools, etc. This question pertains to completing a CHRC specifically for the ND Board of Nursing.</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered "Yes" to the above question #1, what was the month and year of completion of the CHRC?	Month	Year
If you answered "No" to the above question #1, you must submit to a Criminal History Record Check by checking below and completing the attached Criminal History Record Check Instructions.		
<input type="checkbox"/> As part of this application process, I agree to submit to a Criminal History Record Check.		
Follow all Criminal History Record Check instructions found on the last page carefully. Make sure to follow the website link for the CHRC form. This form MUST be sent in along with all other items listed in #2 of the CHRC instructions.		
A nonrenewable temporary permit will be issued to applicants that have met all other requirements for licensure or registration and have agreed to submit to a criminal history record check according to NDCC 43-12.1-09.1. The temporary permit will be listed on the ND Board of Nursing website at www.ndbon.org in the "Verify Permits, Licenses, Registries" section. No hard copy temporary permits will be issued.		

REGISTRY INFORMATION

1. Are you currently registered as an Unlicensed Assistive Person, Technician or Medical Assistant at the ND Board of Nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you checked "yes" to question #1 above, fill in the following information →	UAP registry number	Expiration Date

ALL QUESTIONS MUST BE COMPLETED

1.	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony or misdemeanor offense(s)? Must Answer YES if: A conviction has been pardoned, dismissed, expunged, sealed, stayed, deferred, or suspended; or If you have entered into any agreement by which an offense would be dismissed upon completion of certain terms.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Are there any pending charges against you with respect to a felony or misdemeanor offense?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Have you had an unlicensed assistive person registry or nurse aide registry listing marked for abuse, neglect or misappropriation of property?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you been investigated or are you presently being investigated by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you been denied registration or nursing licensure by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Have you been terminated from a nursing related job due to conduct that may be grounds for disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Do you currently have a diagnosis of chemical dependency or are you participating in chemical dependency treatment/rehabilitation or an alternative to discipline/monitoring program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Are you currently experiencing a physical, emotional, or mental condition that may impair your ability to practice nursing with reasonable skill and safety?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If your answer is "YES" to any question above, attach a detailed written explanation and related legal documents to the application and send to the board.			

APPLICANT CERTIFICATION AND SIGNATURE

I certify the information provided is true, correct, and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.	
Signature	Date

INSTRUCTIONS

1. Complete the Medication Assistant Application.
2. Attach appropriate Medication Assistant non-refundable application/processing fee payable to the ND Board of Nursing
 - ◆ \$60 if you answered “YES” the “Registry Information” question above (*Are you currently registered as an Unlicensed Assistive Person, Technician or Medical Assistant at the ND Board of Nursing?*).
 - ◆ \$100 if you answered “NO” to the “Registry Information” question above (*Are you currently registered as an Unlicensed Assistive Person, Technician or Medical Assistant at the ND Board of Nursing?*).
3. If you answered “no” to the Criminal History Record Check question in this application:
 - ◆ Follow the attached Criminal History Record Check Instructions to complete your fingerprinting process.
4. Attach additional documentation as required
 - ◆ Verification of Eligibility for Medication Assistant Registry” form **OR**
 - ◆ A copy of your certification or registration and have your school send Official Transcripts-
 - *Preferred Method* - Transcripts may be sent electronically through one of the following or another secure transcript service.
 - National Clearing House
 - e-script
 - Parchment
 - If prompted by a secure transcript service to enter an email address for ND Board of Nursing use transcripts@ndbon.org
 - You may use the Request for Release of Transcript form if you are requesting a paper copy from your school.
You will find the form here - <https://www.ndbon.org/UAP-MAIII/Overview.asp> -scroll down to the Related Information section.
5. Submit all of the above to:
North Dakota Board of Nursing
919 S 7th Street, Suite 504
Bismarck, ND 58504-5881
Email- UAP_MAIII@ndbon.org

CRIMINAL HISTORY RECORD CHECK (CHRC) INSTRUCTIONS

1. Submit an online RN or LPN initial application by exam or endorsement OR include one of the following forms:
 - An RN or LPN Reactivation Form or;
 - An initial APRN application or;
 - A UAP/Technician/MAIII initial or reactivation form
1. Contact your local law enforcement agency or a private agency that provides fingerprinting services to make an appointment to be fingerprinted.
 - a. Fee for fingerprinting will vary depending upon agency charges.
 - Agencies and law enforcement are to use the standard FBI Applicant card (FD-258) for fingerprints.
2. Submit the following to North Dakota Board of Nursing (NDBON) - address is at bottom of this form:
 - Criminal History Record Check form at:
<https://attorneygeneral.nd.gov/sites/ag/files/documents/CHR-Request-SFN60688.pdf> - Complete the last section titled "To be Completed by Subject of Record Check" only. Also sign and date form.
 - Completed fingerprint cards (from the law enforcement agency/private agency)
 - TWO completed fingerprint cards if ink and roll
 - ONE completed fingerprint card if electronic
 - Do not fold fingerprint cards
 - Money Order or Cashier Check for **\$41.25**, with a **current date**, and must be made **PAYABLE TO BCI. (No personal checks accepted)**
3. NDBON will submit the completed form, fee, and fingerprint cards to Bureau of Criminal Investigations (BCI).
 - BCI will return the background check results to NDBON.
 - If fingerprints are rejected by BCI, NDBON will notify you.

Required fields to be completed at the top of the fingerprint card using BLACK ink:

- ❖ Last Name, First Name, Middle Name
- ❖ Signature of Person Fingerprinted (Your Signature)
- ❖ Aliases/AKA (**Do Not Leave Blank**)
 - Maiden name
 - Other names used by you
 - **Insert N/A if you have none**
- ❖ Date of Birth (MM/DD/YYYY format)
- ❖ Residence of Person Fingerprinted (Your physical residence address NOT mailing address)
- ❖ Citizenship (US or other country)
- ❖ Sex (M for male; F for female)
- ❖ Race
 - A - Asian/Pacific Islander
 - B – Black/African American
 - I - American Indian or Alaskan Native
 - W - White or Hispanic
 - U - Unknown
- ❖ Height (Enter in feet & inches. Examples-if 5 feet 7 inches tall enter 507; if 5 feet 10 inches tall enter 510)
- ❖ Weight (in pounds)
- ❖ Eyes (color- use code from color code box below)
- ❖ Hair (color- use coed from color code box below)
- ❖ Place of birth (If in US, use 2 letter state abbreviation. If foreign country, enter full name)
- ❖ Date (date prints taken)
- ❖ Signature of Official Taking fingerprints
- ❖ Social Security Number (Use XXX-XX-XXX format)

If fingerprint cards are incomplete you will be required to submit new cards

North Dakota Board of Nursing
919 S 7th St, Suite 504
Bismarck, ND 58504-5881
Email - chrc@ndbon.org

Reviewed/Revised: 05/21

Eye and Hair Color Codes

BLK	Black	GRY	Gray	GRN	Green
BRO	Brown	HAZ	Hazel	MUL	Multi-colored
BLN	Blond or Strawberry	WHI	White	SDY	Sandy
RED	Red or Auburn	BLD	Bald	MAR	Maroon
PNK	Pink	BLU	Blue	ONG	Orange
PLE	Purple				