DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATION

APPLICATION FOR CERTIFIED MEDICATION AIDE PAYMENT INVOICE

I wish to apply to become a certified medication aide (CMA) in Georgia. I understand that I must meet all of following requirements:

- I must be a certified nurse aide (CNA) in good standing on the Georgia CNA Registry.
- I must take and successfully complete the approved CMA training program which has been administered by a Georgia-licensed physician, registered nurse or pharmacist.
- I must pass a skills competency checklist for medications administered to me by the Georgia-licensed physician, registered nurse or pharmacist.
- I must also pass an on-line written competency test that is proctored by an approved CMA Instructor through the Alliant Health Solutions website (www.mmis.georgia.gov) with a satisfactory score.
- I must pay $25.00 to the Healthcare Facility Regulation Division, Department of Community Health, to take the written competency test.
- **I understand that the fee of $25.00 is NOT REFUNDABLE, even if I do not pass the written competency test.**

DIRECTIONS FOR PAYMENT

1. **COMPLETE AND PRINT THIS PAYMENT INVOICE FOR EACH CMA APPLICAN**T.
2. MAKE SURE YOUR CNA # IS CORRECT AND YOU HAVE INCLUDED YOUR MONTH AND DAY OF BIRTH.
3. MAKE YOUR **CHECK OR MONEY ORDER FOR $25.OO** PAYABLE TO: **HEALTHCARE FACILITY REGULATION, DCH**.
4. **PUT YOUR CNA # ON THE CHECK OR MONEY ORDER IN THE MEMO FIELD TO ENSURE PROPER CREDIT.**
5. MAIL **ONLY CHECK OR MONEY ORDER (NO CASH)** AND **THIS INVOICE** TO:

GA DEPT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION
P O BOX 734653
DALLAS, TX 75373-4653

YOU MUST PROVIDE ALL OF THE INFORMATION LISTED BELOW TO ENSURE THAT YOUR PAYMENT IS PROPERLY CREDITED TO YOUR CMA APPLICATION. If you do not know your CNA #, you can find it on this website: https://www.mmis.georgia.gov/portal/PubAccess.Nurse%20Aide/tabId/71/Default.aspx

FULL NAME: (First Name, Middle Initial, Last Name - Must Be Same As Listed on CNA Registry. If name has changed, contact CNA registry to change name there first.)
ADDRESS:
CITY: **STATE: GA** **ZIP CODE:**
PHONE NUMBER:
CERTIFIED NURSE AIDE #:
MONTH AND DAY OF BIRTH: