Washington State Department of HEALTH

Medication Assistant Endorsement
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Supervised Work Experience

Applicant: Use a separate form for each supervisor verifying your direct supervision and work experience for each nursing home practice setting. Fill out section one and forward to the supervisor for completion.

1. Print or type clearly:

Name Last	First	Middle

Birth Date (mm/dd/yyyy)	Social Security Number

Address		

City	State	Zip Code

2. Approved Supervisor: (must be a licensed registered nurse)

The above individual seeks verification of direct supervised nursing assistant-certified work experience for medication assistant endorsement. Please complete the following:

Supervisor Name		Phone (enter 10 digit #)

Credential State	Credential Number	First Issuance Date

Current Street Address		

City	State	Zip code

3. Direct Supervised Work Experience

Applicants must provide at least 1000 hours of direct supervised work experience in a nursing home as a nursing assistant-certified within the immediate year prior to the date of application for medication assistant endorsement. Please complete the actual months in the space provided below.

Months of Direct Supervision	From: mm/dd/yyyy	To: mm/dd/yyyy

A. Direct Supervision, means that the licensed register nurse who delegated medication administration and selected resident treatments to a medication assistant is on the premises, is quickly and easily available in person and has assessed the residents prior to the delegation of these duties.	At least 1000 hours required	Total hours verified
B. Total Hours required	Total of 1000	

Supervisor: I certify that the above information is to the best of my knowledge, accurate and complete. I understand that the Department may request additional information if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed that educational and supervision requirements to be an approved supervisor.

Signature _____ Date _____