PROVIDER MEMORANDUM OF AGREEMENT

Agreement made this _____ day of _____________, 20____ by and between **Kentucky Health Care Training Institute**, 3010 Taylor Springs Dr., Louisville, KY. 40220, hereinafter referred to as **KHCTI**, and ________________________________ located at ____ hereinafter referred to as the **Facility**

Whereas, **KHCTI** is in the business of providing training for medication aides, and

Whereas, **Facility** is agreeable to allow ___________________________, hereinafter referred to as **Student**, to receive clinical experience and precepting in its long-term care facility.

Now therefore, it is hereby agreed as follows:

1. **Facility** herewith agrees to allow **Student** to complete clinical training as a medication aide in this location.
2. **Facility** will appoint a registered nurse or licensed practical nurse to appropriately supervise and monitor the actions of **Student** while he or she is gaining the clinical experience, and under no circumstances will the student(s) render patient care unless under the direct supervision of the appointed nurse. The nurse evaluating the **Student's** performance shall follow assessment instructions issued by **KHCTI**, and will return evaluations forms to the **Student** for submission to **KHCTI**. Each **Student** must acquire a minimum of 40 hours of clinical experience in the administration of medications. Medication aides are specifically prohibited from instilling medications through a tube, giving parenteral medications, converting from one dosage system to another, administering antineoplastic drugs, accepting phone/verbal orders from those with prescriptive authority, dispensing medications for residents temporarily out of the facility, and performing any procedure that requires sterile technique. **This clinical work is not started until the student has successfully completed the classroom portion of the course.**
3. Once the clinical portion has been completed, **Facility** will appoint a certified medication aide or a nurse to precept the **Student** for at least 60 hours of medication administration. (The preceptor supervising the **Student** must either be a nurse licensed in Kentucky, OR be a currently certified medication aide who has at least 6 months of experience administering medications in a long term care facility.) The preceptor shall follow instructions provided by **KHCTI**, and will return required forms to the **Student** for submission to **KHCTI,** after the precepting experience is completed.
4. The **student** shall acquire adequate professional liability insurance either through the clinical facility or through a company the student has purchased a policy from.

BY____

(Signature) Title: (circle one): **Director of Nursing** or **Administrator**

Name of DON/Administrator (printed)____

Email address ____

Date ____

BY ____

Christina Gnadinger, RN, BSN, Director, KHCTI