## PROVIDER MEMORANDUM OF AGREEMENT FOR KMA STUDENTS

Agreement made this	day of	,	20	by	and b	between
Kentucky Health Care	Training Institute, 301	0 Taylor	Springs	Dr., I	Louisvi	lle, KY.
40220, hereinafter refer	red to as KHCTI, and					
located at			hereii	nafter	referre	ed 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 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. 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. 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 \_\_\_\_\_


BY \_\_\_\_\_ Director, KHCTI