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 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 Certified Medication Aide II (CMA II) in this location.

2. **Facility** will submit nursing license validation and resumes for each potential clinical instructor overseeing this student's clinical training for review and approval by **KHCTI**.

3. **Facility** will appoint a KHCTI- approved 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,** once the clinical experience is complete. Each **Student** must acquire a minimum of 8 hours of clinical experience, during which a minimum of 20 documented insulin injections, using a prefilled insulin pen, must be completed. The clinical experience must be completed within 60 days of completion of the classroom portion of the course. Certified Medication Aides (Level II) are specifically prohibited from administering insulin using a syringe, or administering intravenous insulin/fluids. **This clinical work is not started until the student has successfully completed the classroom portion of the course.**

4. The **student** shall acquire adequate professional liability insurance either through the clinical facility or through a company from which the student has purchased a policy.

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