



Faith Healthcare Training Center
4102 East Washington Street
Indianapolis, Indiana 46201
(Office) 317-672-3374
(Text or Call) 1-888-708-2967

QMA Practicum - Do's and Don'ts

YOU CANNOT START YOUR 40 PRACTICUM HOURS UNTIL YOU HAVE TURNED IN THE PRACTICUM SITE AGREEMENT FORM AND FHTC HAS SENT YOU A NOTIFICATION INDICATING THAT YOU MAY START. YOUR HOURS WILL BE CONSIDERED INVALID IF YOU START YOUR PRACTICUM BEFORE YOU RECEIVE APPROVAL!

You are allowed to work (10) 4 hour shifts **OR** (5) eight hour shifts

Document in 4 hour increments

- Do not list more than 4 hours at a time
- Less than 4 hours can be documented
- If you work an 8 hour shift, it must be separated by a 30 minute - 1 hour break

Incorrect Example:

Date	Start Time	End Time	Total Hours
2-14-25	6am	10am	4 hours
2-14-25	10am**	2:30pm	4.5 hours**

******You must have a 30 minute to 1 hour break in between each 4 hours if you are working an 8 hour shift. You cannot document more than 4 hours in a single entry. Your med pass start and end time can vary according to your facility.******

Correct Example:

Date	Start Time	End Time	Total Hours
2-14-25	6am	10am	4 hours
2-14-25	10:30am	2:30pm	4 hours

- Each entry must have a date regardless if it is on the same day
- Your preceptor nurse (RN or LPN) must print their full name legibly
- Your preceptor nurse (RN or LPN) must sign their full name legibly (first and last name **OR** first initial and last name
- All tasks are not expected to be done during your 40 hours of practicum, but try to get as much done as possible
- You are allowed to have repeated tasks
- If there is an error on the document, the person creating the error, must draw a single line through the error and initial and date the mistake
- DO NOT use white out
- DO NOT scribble out errors, just draw a single line through it and make sure the person correcting the error puts their initials or the document will get rejected.
- Use black ink only- DO NOT use pencils, blue ink or colored pens

- Include these tasks on each entry as you will do this on a daily basis as a QMA. Each day you do your hours, please include these task numbers:

- #1 - Initial Steps
- #2 - Final Steps
- #9 - Oral Temperature
- #13 - Pulse and Respirations
- #14 - Blood Pressure
- #15 - Preparing oral tablets or capsules
- #40 - Blood glucose testing via fingerstick

*** Just list the number of the task as you DO NOT have to write out the name of the task. It will not be enough room to write it out so please just write the number.

**** You will perform all of the above 7 tasks on a daily basis, so document it. Include additional tasks that you may have done that day, but make sure to include those 7 tasks each day****

- QMA Practicum of 40 hours cannot be started until the completion of 60 hours of classroom theory
- QMA practicum of 40 hours has to be completed within 3 months of classroom theory completion
- QMA application must be submitted within 30 days of completing the 40 hours of practicum
- QMA State Exam application must be submitted within 6 months of classroom theory completion

There are 4 ways that you can submit your documents to us:

- 1 - Email: info@faithhtc.com
- 2 - Text: 1-888-708-2967
- 3 - In-person
- 4 - Mailbox (There is an open slot at the top of box)
- 5 - **NO FAX** (We do not have a fax line)

P.S. When emailing or texting your documents, please make sure you take the photo in a well lit area, your document is readable and that there are no additional images in the background.



Qualified Medication Aide- Practicum Site Agreement

Name of School: **Faith Healthcare Training Center #014732**

Address of School: **4102 East Washington Street Indianapolis, Indiana 46201**

Contact Number: **317-672-3374**

Faith Healthcare Training Center (FHTC) is approved by the Indiana Department of Health (IDOH) to conduct the QUALIFIED MEDICATION AIDE (QMA) training program which requires an affiliation agreement with a licensed nursing facility.

The practicum must be done under the 1:1 supervision of a licensed nurse (RN or LPN). The sessions **MUST** be completed in 4-hour increments. Written permission is required by IDOH and is also the policy of FHTC. The QMA student must perform as many procedures / skills as possible during their practicum as this is their hands on experience to complete the 100-hour QMA Program which includes 45 procedures / skills being taught in the course.

Practicum will be conducted in accordance with Indiana State Laws and Regulations, including but not limited to 410 IAC 16.2, IC 16-28-1-11, IC 16-28-1-11.5 and IDOH QMA program standards.

Complete the following to confirm that the student is able to complete their 40 hours of practicum at this facility.

(Student Name) _____ has written permission from the Director of Nursing (DON), Administrator, Executive Director (ED) or designee to complete the 40-hour practicum requirement at

Name of Facility: _____ Address of Facility: _____

Facility Contact Number: _____

Upon completion of the agreement a copy of this document with all signatures will be sent.

Practicum Site Representative Signature and Title

Date

Practicum Site Representative Printed Name and Title

Phone number: _____ Email: _____

Signature of School Representative

Date

Victoria R. Davis MSN RN CCM - Program Director
Faith Healthcare Training Center
1-317-672-3374 (o)
victoria@faithhtc.com



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VERIFICATION OF CNA HOURS WORKED FHTC QUALIFIED MEDICATION AIDE (QMA) PROGRAM

I, _____ a representative of _____
(Representative Name) (Facility Name)

verify that _____ has worked the hours shown below.
(Name of QMA applicant)

Total Hours Worked: _____

Date(s) of Employment: _____

Signed Name of Facility Representative & Title: _____

Date: _____

Email Address: _____ Phone Number: _____

NOTES / UPDATES - FOR OFFICE USE ONLY

REVIEWED BY: _____ DATE: _____

To remain in student file for a minimum of 5 years

Revised: 3-2025



DOCUMENTATION OF QUALIFIED MEDICATION AIDE PRACTICUM

State Form 51650 (R3 / 2-24)

INDIANA DEPARTMENT OF HEALTH

CONSUMER SERVICES & HEALTH CARE REGULATION

This form must be uploaded with your application to test.

Student Name: _____

IDOH Approved QMA Training Program: _____

Practicum Site: _____ TOTAL PRACTICUM HOURS: 40 hours (Required)

Read Directions Carefully: List **complete** dates (including year) and complete times (including am or pm). Document **only** time spent performing duties & tasks as mandated in the IDOH QMA program. **Use the "Task #s" on the "QMA Procedure Performance Checklist" to document completed tasks in the "Description of Tasks Completed" column. Do Not include time spent on other duties, breaks or meals.** Use multiple forms as necessary.

A maximum of two **4-hour increments**, which **must be divided by at least a 30-minute break**, may be completed in a 24-hour period of time.

Date	Start Time	Ending Time	Total Time	Description of Tasks Completed	Practicum Supervisor Printed Name	Practicum Supervisor Nursing License #	Practicum Supervisor Signature	Student Initials

Total Practicum Hours: _____

I verify that the above stated hours are correct and are the actual times of medication and treatment administration.

RN QMA Training Program

Instructor Signature _____

Student Signature _____

Date _____

QMA Procedure Performance Checklist

Initials:

Student	Instructor	Date	Task #	Procedure Title (Corresponding Lesson #)
			1	Initial Steps (Introduced in Lesson #3 and repeated prior to Lesson #51)
			2	Final Steps (Introduced in Lesson #3 and repeated prior to Lesson #51)
			3	Supine Position (Lesson #32)
			4	Sim's Position (Lesson #32)
			5	Fowler's Position (Lesson #32)
			6	Semi-Fowler's Position (Lesson #32)
			7	Prone Position (Lesson #32)
			8	Dorsal Recumbent Position (Lesson #32)
			9	Obtaining an Oral Temperature Using an Electronic Thermometer (Lesson #33)
			10	Obtaining a Rectal Temperature Using an Electronic Thermometer (Lesson #33)
			11	Obtaining an Axillary Temperature Using an Electronic Thermometer (Lesson #33)
			12	Obtaining a Tympanic (Aural) Temperature (Lesson #33)
			13	Obtaining the Pulse (Apical & Radial) and Respiratory Rate (Lesson #34)
			14	Obtaining the Blood Pressure (Lesson #35)
			15	Preparing Oral Tablets or Capsules (Lesson #36)
			16	Preparing Liquid Medications (Lesson #37)
			17	Preparing Powdered Medications (Lesson #38)
			18	Crushing Tablets (Lesson #39)
			19	Altering Capsules (Lesson #40)
			20	Preparing Controlled Substances for Administration (Lesson #41)
			21	Counting Controlled Substances/Responding to Errors in a Controlled Substance Count (Lesson #42)
			22	Applying Lotion, Liniment, Ointment or Cream (Lesson #43)
			23	Applying a Transdermal Patch (Lesson #44)
			24	Instilling Eyedrops (Lesson #45)
			25	Instilling Ophthalmic Ointment (Lesson #45)
			26	Instilling Eardrops (Lesson #46)
			27	Instilling Nasal Drops (Dropper) (Lesson #47)
			28	Instilling Nasal Medication Using an Atomizer (Lesson #47)
			29	Inserting a Vaginal Suppository (Lesson #48)
			30	Administering a Vaginal Cream (Lesson #48)
			31	Inserting a Rectal Suppository (Lesson #49)
			32	Administering Medications via the Gastrostomy Tube (G-Tube) or Jejunal Tube (J-Tube) (Lesson #51)
			33	Applying a Dressing to a Healed Gastrostomy Tube (G-tube) or Jejunal Tube (J-tube) Site (Lesson #52)
			34	Administration of Medication via Metered Dose Inhaler (MDI) (Lesson #53)
			35	Applying a Transparent Dressing to a Minor Skin Tear (Lesson #54)
			36	Scabies Treatment (Lesson #55)
			37	Pediculosis Treatment (Lesson #55)
			38	Emptying and Changing a Colostomy Bag (Lesson #56)
			39	Applying a Cold, Dry Compress (Lesson #57)
			40	Blood Glucose Testing via Finger Stick (Lesson #58)
			41	Collecting Urine Specimens (Lesson #59)
			42	Collecting Fecal Specimens (Lesson #59)
			43	Hemoccult Testing (Lesson #59)
			44	Oxygen Administration (Lesson #60)
			45	Instilling a Commercially Prepared Disposable Enema (Lesson #61)

The Qualified Medication Aide student may have more than one practicum supervisor or instructor. Please make sure each practicum supervisor or instructor initials and signs this form.

I verify that these procedures were taught and demonstrated with 100% accuracy according to IDOH standards.

Student's signature: _____ Date: _____

QMA practicum supervisor's signature, initials, and title: _____

Date(s): _____

QMA practicum supervisor's signature, initials, and title: _____

Date(s): _____

QMA practicum supervisor's signature, initials, and title: _____

Date(s): _____

QMA practicum supervisor's signature, initials, and title: _____

Date(s): _____

QMA practicum supervisor's signature, initials, and title: _____

Date(s): _____

PLEASE NOTE: The "Task #s" on this "QMA Procedure Performance Checklist" should be used to document the "Description of Tasks Completed" on the "Documentation of Qualified Medication Aide Practicum" form.

ANNUAL PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED BY PATIENT BEFORE MEDICAL APPOINTMENT

Name: _____

Date of Exam: _____

Address: _____

Date of Birth: _____

City and State: _____

Sex: ☐ Male ☐ Female

DIAGNOSES / SIGNIFICANT HEALTH CONDITIONS

CURRENT MEDICATIONS *(Attach a second page if needed):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: _____

HOSPITALIZATIONS/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: ____/____ Pulse: ____ Respirations: ____ Temp: ____ Height: ____ Weight: ____

EVALUATION OF SYSTEMS

System Name	Normal findings?		Comments/Description
Eyes	☐ Yes	☐ No	
Ears	☐ Yes	☐ No	
Nose	☐ Yes	☐ No	
Mouth/Throat	☐ Yes	☐ No	
Head/Face/Neck	☐ Yes	☐ No	
Breasts	☐ Yes	☐ No	
Lungs	☐ Yes	☐ No	
Cardiovascular	☐ Yes	☐ No	
Extremities	☐ Yes	☐ No	
Abdomen	☐ Yes	☐ No	
Gastrointestinal	☐ Yes	☐ No	
Endocrine	☐ Yes	☐ No	
Musculoskeletal	☐ Yes	☐ No	
Integumentary	☐ Yes	☐ No	
Renal/Urinary	☐ Yes	☐ No	
Reproductive	☐ Yes	☐ No	
Lymphatic	☐ Yes	☐ No	
Nervous System	☐ Yes	☐ No	
VISION SCREENING	☐ Yes	☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No
HEARING SCREENING	☐ Yes	☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No

Additional Comments:

Limitations or restrictions for activities (including workday, lifting, standing, and bending) ☐ No ☐ Yes (specify):_____
Name of Provider Completing Exam (please print)_____
Medical Provider Signature_____
Date

Medical Provider Identification Number: _____

Medical Provider Phone Number: _____

Patient Signature: _____ Date: _____



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PPD Skin Test Form

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Step #1

Date: _____ Time Given: _____ Site: ☐ Rt Arm ☐ Lt Arm _____	Manufacturer: _____ Dose: _____ Exp. Date: _____ Lot #: _____ Administered By: _____ Signature
Date: _____ Time Read: _____ *within 48-72 hours from date placed*	Results: _____ mm Read By: _____ Signature Results: ☐ Negative ☐ Positive
If Mantoux Positive: Chest X-Ray Required	

Step #2 (No sooner than 7 days after Step #1)

Date: _____ Time Given: _____ Site: ☐ Rt Arm ☐ Lt Arm _____	Manufacturer: _____ Dose: _____ Exp. Date: _____ Lot #: _____ Given By: _____ Signature
Date: _____ Time Read: _____ *within 48-72 hours from date placed*	Results: _____ mm Read By: _____ Signature Results: ☐ Negative ☐ Positive
If Mantoux Positive: Chest X-Ray Required	