Healthcare Facility Regulation Division
Department of Community Health

APPLICATION FOR CERTIFIED MEDICATION AIDE
PAYMENT INVOICE

I wish to apply to become a certified medication aide (CMA) in Georgia. I understand that I must meet all of the following requirements:

- I must be a certified nurse aide (CNA) in good standing on the Georgia CNA Registry.
- I must take and successfully complete the approved CMA training program which has been administered by a Georgia-licensed physician, registered nurse or pharmacist.
- I must pass a skills competency checklist for medications administered to me by the Georgia-licensed physician, registered nurse or pharmacist.
- I must also pass a written competency test that is administered through the Georgia Medical Care Foundation website with a satisfactory score.
- I must pay $25.00 to the Healthcare Facility Regulation Division, Department of Community Health, to take the written competency test.
- **I understand that the fee of $25.00 is NOT REFUNDABLE, even if I do not pass the written competency test.**

DIRECTIONS FOR PAYMENT

1. **COMPLETE AND PRINT THIS PAYMENT INVOICE FOR EACH CMA APPLICANT**.
2. **MAKE SURE** YOUR **CNA # IS CORRECT** AND YOU HAVE **INCLUDED YOUR MONTH AND DAY OF BIRTH**.
3. MAKE YOUR **CHECK OR MONEY ORDER FOR $25.OO** PAYABLE TO THE HEALTHCARE FACILITY REGULATION DIVISION, DCH.
4. **PUT YOUR CNA # ON THE CHECK OR MONEY ORDER IN THE MEMO FIELD TO ENSURE PROPER CREDIT.**
5. MAIL **ONLY CHECK OR MONEY ORDER (NO CASH)** AND **THIS INVOICE** TO:

HEALTHCARE FACILITY REGULATION DIVISION
P. O. BOX 741328
ATLANTA, GA. 30374-1328

YOU MUST PROVIDE ALL OF THE INFORMATION LISTED BELOW TO ENSURE THAT YOUR PAYMENT IS PROPERLY CREDITED TO YOUR CMA APPLICATION.
(If you don't know your CNA #, you can find it on this website:
https://www.mmis.georgia.gov/portal/PubAccess.Nurse%20Aide/tabId/71/Default.aspx)

FULL NAME: (First Name, Middle Initial, Last Name—Must Be Same As Listed on CNA Registry. If name has changed, contact CNA registry to change name there first)	
ADDRESS:	
CITY:	STATE: Georgia
ZIP CODE:	PHONE NUMBER:
CERTIFIED NURSE AIDE #:	MONTH AND DAY OF BIRTH (use numbers 00/00):
CN	