

MEDICATION ADMINISTRATION CERTIFICATION TRAINING

Application for Attending Certification Course **Instructions**

Thank you for registering to complete medication administration training.

To complete your registration, please complete the attached application and submit to Geauga County Board of DD's Provider Support, **no less than 5 days prior to the course date.**

- **Independent Providers:** Complete the application in its entirety (page 1 and 2)
- **Agency/ICF Provider Staff:** Employer complete page 1, staff person completes page 2

Please send completed applications to:
providersupport@geaugadd.org

Application for Personnel to Attend the DODD Medication Administration (MA) Certification Course



**Department of
Developmental
Disabilities**

Prior to DODD Medication Administration Certification (Initial Certification class or Renewal): DD Personnel must submit a completed application to the RN Trainer, including all Employer and Personal information and signatures. DD Personnel whose application forms are not completed or without required signatures are not eligible for DODD Medication Administration certification.

Page 1 must be fully completed by the employer.

| | | | |
|--|---|---|--|
| DD personnel name | Date of application | Are you? <input type="checkbox"/> Agency Employer <input type="checkbox"/> DODD Certified Independent Provider | |
| <i>If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer.</i> | Employer | DODD Provider Number | |
| Work location address | Email Phone # | Work location start date | |
| Name of supervisor of DD personnel | Title of supervisor of DD personnel | Email of supervisor of DD personnel | |
| Phone of supervisor of DD personnel | Date supervisor began supervision of DD personnel | | |

Please verify all of the following are true as of the date of the application.

- This person is employed by the agency Yes Start date _____
- This person is at least 18 years of age Yes
- The agency has been provided documented proof of this person's high school diploma or GED Yes
- All background check requirements have been completed according to OAC 5123-2-02 including results and registry checks within the specified time frames Yes

As the agency employer of the DD personnel whose name appears on this application, I attest that all information provided on this application is accurate and current.

Print name and title of agency employer or designee

Signature of agency employer or designee

Date

Application for Personnel to Attend the DODD Medication Administration (MA) Certification Course

Page 2 must be completed by DD personnel.

Prior to attending a DODD MA Certification Course: DD Personnel are required to complete this application, including all information and signatures. Without a completed application DD Personnel will not be eligible for DODD Medication Administration certification to administer medications.

This application is for

| | | |
|---|--|---|
| <input type="checkbox"/> (Cat. 1) Medication Administration | <input type="checkbox"/> (Cat. 2) G/J Tube Medications | <input type="checkbox"/> (Cat. 3) Insulin |
| <input type="checkbox"/> (Cat. 1) Renewal | <input type="checkbox"/> (Cat. 2) Renewal | <input type="checkbox"/> (Cat. 3) Renewal |

Have you ever taken a medication administration certification class before this application? Yes No

| | | | | | |
|------------|----------------|-----------|---------------|---------------|---|
| First name | Middle Initial | Last name | Last 4 of SSN | Date of birth | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------------|----------------|-----------|---------------|---------------|---|

| | |
|--|--|
| Are you an independent provider? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, do you have (must provide proof to RN Trainer) <input type="checkbox"/> High school diploma <input type="checkbox"/> High School Equivalency Document |
|--|--|

| | | | | |
|-------------------------|------|-------|-----|--------|
| Personal street address | City | State | Zip | County |
|-------------------------|------|-------|-----|--------|

| | | | |
|------------|------------|------------|-------|
| Home phone | Work phone | Cell phone | Email |
|------------|------------|------------|-------|

| | | |
|---|--|-----------------------|
| At the time of this application, do you work for more than one DD employer? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, print the names and provider number of all DD employers you currently work for | |
| | DD employer _____ | Provider number _____ |
| | DD employer _____ | Provider number _____ |

I attest that all information provided in this application is true, current, and correct.

Signature of DD personnel _____
Date

RN trainer should keep this application in a retrievable file, which is accessible to authorized personnel and DODD upon request for at least 7 years.

RN trainer signature (Includes validation of HSD/GED for independent providers) _____
Date _____
Session number (If initial certification, not renewal)