# 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? ☐ Agency Employer ☐ DODD Certified Independent Provider | |
| *If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer.* | Employer | | DODD Provider Number |
| Work location address | | Email<br>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

- ☐ (Cat. 1) Medication Administration
- ☐ (Cat. 2) G/J Tube Medications
- ☐ (Cat. 3) Insulin
- ☐ (Cat. 1) Renewal
- ☐ (Cat. 2) Renewal
- ☐ (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 |
|---|---|---|---|---|---|
| | | | | | ☐ Male ☐ Female |

Are you an independent provider? ☐ Yes ☐ No

If yes, do you have (must provide proof to RN Trainer) ☐ High school diploma ☐ 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? ☐ Yes ☐ 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)