Metro Support Services

MEDICATION ADMINISTRATION DISCLOSURE FORM

Student Name: ______________________________________

Agency/Employer: __________________________________

Social Security Number: ____________________________

I declare that I have never had a professional license to practice nursing, medicine, or pharmacy revoked in this or any other state for reasons directly related to the administration of medications.

I understand that successful completion of this course does not certify or license me to administer medications. This course is designed to qualify me to perform only the tasks taught in this course. After successfully completing this course I am considered qualified to administer medications as a Qualified Medication Administration Personnel (QMAP).

I understand this course does not authorize me to assess, evaluate, or use judgement in regard to a client's physical, mental condition or medication utilization. Successful completion of this course does not authorize me to give injections or perform other invasive procedures.

I understand that I may be required to re-take the approved medication administration course and competency evaluation if the Colorado Department of Public Health Environment (CDPHE) or my agency determines the need for such training as result of survey, complaint, investigation, or other review process.

I have been informed about the guidelines for QMAP's filling medication reminder boxes (MRB).

I understand that the documentation of completion form signifying satisfactory completion of this course is to be retained by me and that a duplicate may not be available from the instructor.

Student Signature:____

Instructor Signature:____