BCC APPLICATION FOR MEDICATION CERTIFICATION COURSE FOR DD PERSONNEL

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| ALL INFORMATION MUST BE COMPLETED AND RETURNED  FOR THIS APPLICATION TO BE PROCESSED |

Date of Application □ Certification 1 □ Renew □ Certification 2 □ Renew □ Certification 3 □ Renew

**\***Participant Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*M/F:\_\_\_\_\_\_\_\_\_

**\***Date of Birth\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **\***S.S.# XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_ \*Hire Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Have you taken this class before? Yes \_\_\_\_\_ No \_\_\_\_\_\_ **\***Start Date at location: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**\***Are you a high school graduate? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_ Diploma \_\_\_\_\_ / High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GED\_\_\_\_\_\_

**\***Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\***Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Home Phone: \_(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\***Cell Phone: \_(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Current Employer Name: \_**

**\*Provider #: \*Phone: / fax**

**\***Immediate Supervisor (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\***Supervisor Phone # (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Supervisor email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\***Date Supervision Began: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

**\***Work location address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OH \_\_\_\_\_\_\_\_\_ \*Phone: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*At the time of this application, do you work for more than one DD employer? \_\_\_ NO \_\_\_\_ YES (If so, fill next section)**

DD Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DD Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I attest that all information provided on this application is true, current, and accurate:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF DD PERSONNEL/ MED PASSER DATE**

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**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.** DDID: DD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPID: \_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_**

**SIGNATURE OF RN Trainer DATE**

**Course Code/ Session**\_\_**\_\_\_\_\_\_\_\_\_\_\_\_ \_**\_\_/\_**\_\_\_253537-3-01-8356 \_\_\_\_\_\_\_\_**\_(For initial certification – not renewal)\_

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| \*Employer Use (Human Resources)(It is mandatory that this section be signed by authorized HR personnel PRIOR to class.) Prior to permitting an unlicensed worker to take the medication course, the employer of the unlicensed worker shall  **VERIFY ALL OF THE FOLLOWING ARE TRUE AS OF DATE OF THIS APPLICATION:**   * \_\_\_\_\_\_ **\***Employed by Agency **\***Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_ **\***This person is 18 years of age or older * \_\_\_\_\_\_ **\*** The agency has been provided documented proof of this person’s high school diploma or   equivalency.   * \_\_\_\_\_\_\_ **\***Employee checks compliant to OAC 5123:2-6-06(A) (1)(2), (B)(1)(2)(3) **AND** OAC 5123:2-2-02 including registry checks within the specified time frames.   **The following signature is indicative that these checks have been completed and that the applicant, whose name appears above, meets current eligibility requirements.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HUMAN RESOURCES SIGNATURE /Title DATE** |

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DN application Revised 5/19/2014