**Medication Administration Verification Form:**

**CERTIFICATION TWO:**

**Fill in the appropriate information then return email to:****benevolentcarecenters@gmail.com** **or fax to 216-744-2544**

|  |
| --- |
| **The signature below indicates that background checks have been completed and that the applicant(s), whose name(s) appear below, are employed by the Agency, and meet current eligibility requirements.****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **HUMAN RESOURCES/AUTHORIZED SIGNATURE / Title DATE****PRINTED NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PROVIDER NUMBER: q** |

|  |
| --- |
| **Please select which add-on class you are providing verification for:**  **CERT 2**  **Date of Scheduled Course:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CERT 2 Renewal**  **Time of Scheduled Course:**  \_\_\_\_\_\_\_\_\_ **-** \_\_\_\_\_\_\_\_\_  |
|  | Associate Name | Last 4 of SSN | Start Date | This person is 18 years 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. | **Date of Cert 1 Expiration** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  |  |
| 19 |  |  |  |  |  |  |  |
| 20 |  |  |  |  |  |  |  |