BCC APPLICATION FOR MEDICATION CERTIFICATION COURSE FOR DD PERSONNEL

ALL INFORMATION MUST BE COMPLETED AND RETURNED VIA EMAIL TO BENEVOLENTCARECENTERS@GMAIL.COM OR FAX TO 216-744-2544 FOR THIS APPLICATION TO BE PROCESSED **BOOK NUMBER:**

Date of Application:__________________ *M/F:_________ *Date of Birth_____/_____/______ Title _______________

*Participant Name____ *S.S.# XXX-XX-___________

*Are you a high school graduate? Yes ______ No______ Diploma _____ / High School: _________________ GED______

*Home Phone: _(________)________________________ *Cell Phone: _(________)______________________

*Home Address: _______________________ *City:______________________ *Zip:_________ *County:_____________________

*Email Address: ____

***Current Employer Name:** ____

*Hire Date: _____/_____/_____ ***Provider #:**_____________________ ***Phone:** _______________/________________**fax**

*Immediate Supervisor (Please Print)_____________________________ *Supervisor Phone # (________)__________________

*Supervisor email: _________________________________*Date Supervision Began: ____/_____/____

*Work location address: ____ OH _______

*Phone: (________)______________________ *Start Date at location: _____/_____/_____

***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 #:** ____________________

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

____ ______________________

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

What Class are you registering for? **What BCC Class Date(s) are you requesting?**

☐Cert 1 Initial Class ☐Cert 2 Initial Class ☐Cert 3 Initial Class ____

☐Cert 1 Renewal Class ☐Cert 2 Renewal Class ☐Cert 3 Renewal Class Have you taken this class before? Yes ☐ No ☐

***Certification 1 Expiration Date If Applicable:** _____/_____/_____

*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**

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- 11269**____(For initial certification – not renewal) DN application Revised 7/16/2021