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 _____ ☐ 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 Phone: _(_____)_____ *Cell Phone: _(_____)_____

*Home Address: _____ *City:_____ *Zip:_____

*County:_____ *Email Address: _____

***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**

*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 ***BCC Course Requested**: _____

☐ *Start Date: _____ ***BCC Course Date(s) Requested**: _____

☐ _____ *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)_