**Medication Administration Verification Form:**

**CERTIFICATION ONE**

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

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| **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** |

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| **Please indicate which initial certification 1 class you are providing verification for** **CERT 1**  **Date of Scheduled Course:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CERT 1 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. |
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