

Application for Personnel to Attend the DODD Medication Administration (MA) Certification Course



Department of
Developmental Disabilities

Prior to DODD Medication Administration Certification (Initial Certification class or Renewal): DD Personnel must submit a completed application to the RN Trainer, including all Employer and Personal information and signatures. DD Personnel whose application forms are not completed or without required signatures are not eligible for DODD Medication Administration certification.

Page 1 must be fully completed by the employer.

DD personnel name	Date of application	Are you? ☐ Agency Employer ☐ DODD Certified Independent Provider	
<i>If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer.</i>	Employer	DODD Provider Number	
Work location address	Email Phone #	Work location start date	
Name of supervisor of DD personnel	Title of supervisor of DD personnel	Email of supervisor of DD personnel	
Phone of supervisor of DD personnel	Date supervisor began supervision of DD personnel		

Please verify all of the following are true as of the date of the application.

- This person is employed by the agency ☐ Yes Start date _____
- This person is at least 18 years of age ☐ Yes
- The agency has been provided documented proof of this person's high school diploma or GED ☐ Yes
- All background check requirements have been completed according to OAC 5123:2-2-02 including results and registry checks within the specified time frames ☐ Yes

As the agency employer of the DD personnel whose name appears on this application, I attest that all information provided on this application is accurate and current.

Print name and title of agency employer or designee

Signature of agency employer or designee

Date

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Page 2 must be completed by DD personnel.

Prior to attending a DODD MA Certification Course: DD Personnel are required to complete this application, including all information and signatures. Without a completed application DD Personnel will not be eligible for DODD Medication Administration certification to administer medications.

This application is for

☐ (Cat. 1) Medication Administration

☐ (Cat. 2) G/J Tube Medications

☐ (Cat. 3) Insulin

☐ (Cat. 1) Renewal

☐ (Cat. 2) Renewal

☐ (Cat. 3) Renewal

Have you ever taken a medication administration certification class before this application? ☐ Yes ☐ No

First name		Last name		Last 4 of SSN		Date of birth		Gender ☐ Male ☐ Female	
Are you an independent provider? ☐ Yes ☐ No			If yes, do you have (must provide proof to RN Trainer) ☐ High school diploma ☐ High School Equivalency Document						
Personal street address				City		State	Zip	County	
Home phone		Work phone		Cell phone		Email			
At the time of this application, do you work for more than one DD employer? ☐ Yes ☐ No			If yes, print the names and provider number of all DD employers you currently work for DD employer _____ Provider number _____ DD employer _____ Provider number _____						

I attest that all information provided in this application is true, current, and correct.

Signature of DD personnel

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.

RN trainer signature
(Includes validation of HSD/GED for independent providers)

Date

Session number
(If initial certification, not renewal)