Ohio Department of Developmental Disabilities

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

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.

DD Personnel: (print)_____

PAGE 1: MUST BE FULLY COMPLETED BY EMPLOYER **Date of Application:** _____

Agency Employer? ☐ **OR** **DODD Certified Independent Provider?** ☐

If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer.

EMPLOYER:_____ **DODD PROVIDER NUMBER:** _____

WORK LOCATION: At the time of this application, where does this person primarily provide services or supervision?

☐ **At the address listed above** **OR**

☐ **Other agency location - Address:** _____

_____

Work Location Phone: _____ **E-mail:**_____

(If no direct phone or e-mail at location, list DD employer agency phone and e-mail

SUPERVISOR: At the time of this application, who is the direct supervisor of this DD personnel?

Print Name & Title of direct supervisor: _____

_____

Phone for direct supervisor: _____ **E-mail for direct supervisor:** _____

When did this supervisor begin supervision of this DD personnel? Date: _____

Please verify all of the following are true as of the date of this application:

- **This person is employed by the agency** ☐ **YES** **Start Date:** _____
- **This person at least 18 years of age:** ☐ **YES**
- **The agency has been provided documented proof of this person's high school diploma or equivalency?** ☐ **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 & Title of Agency Employer/Designee

_____ **Date:** _____
Signature of Agency Employer/Designee

Ohio Department of Developmental Disabilities
Application for DD Personnel Medication Administration Certification

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:

Category 1- Medication Administration ☐ **Category 2- G/J Tube Medications** ☐ **Category 3 - Insulin** ☐
Category 1 Renewal ☐ **Category 2 Renewal** ☐ **Category 3 Renewal** ☐

Have you ever taken a medication administration certification class before this application? ☐ **YES** ☐ **NO**

PRINT: Last Name _____

First Name _____ **Middle Initial:** _____

***Last four* digits of social security number:** ____ ____ ____ ___ (not full number)

Date of Birth: __ __/__ __/__ __ __ **Gender:** ☐ **Female** ☐ **Male**

Are you an Independent Provider? ☐ **YES** ☐ **NO** **If yes, do you have:**

☐ **High School Diploma or** ☐ **High School Equivalency Document** **(must provide proof to RN Trainer)**

Personal Address: _____

City: _____ **State:** _____

Zip: _____ **County:** _____

Home: (____)_____ **Work :**(____)_____ **Cell :**(____)_____

Personal E-mail: _____

Your certificates and renewal notices will be sent to you by e-mail.
You MUST provide an e-mail address where you will reliably receive messages.

At the time of this application, do you work for more than one DD employer? ☐ **YES** ☐ **NO**
If YES please print the names and Provider Number of all DD employers you currently work for:

DD Employer: _____ **Provider #** _____

DD Employer: _____ **Provider #** _____

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

_____ **Date:** _____
Signature of DD Personnel

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 # (If Initial Certification – not renewal)