

# 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.

### PAGE 1: MUST BE FULLY COMPLETED BY EMPLOYER

<b>DD PERSONNEL: (print)</b>	Click here to enter text.		<b>Date of Application:</b>	Click here to enter a date.
<b>Agency Employer?</b>	<input type="checkbox"/>	<b>OR</b>	DODD Certified Independent Provider	<input type="checkbox"/>
<b>If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer</b>				
<b>EMPLOYER:</b>	Click here to enter text.		DODD Provider Number	Click here to enter text.
<b>WORK LOCATION:</b>	<b>At the time of this application, where does this person primarily provide services or supervision?</b>			
At the address listed above	<input type="checkbox"/>	<b>OR</b>	Other agency location:	<input type="checkbox"/>
<b>ADDRESS:</b>	Click here to enter text.			
<b>TELEPHONE:</b>	Click here to enter text.	<b>EMAIL:</b>	Click here to enter text.	
<b>If no direct phone or e-mail address at this location, list DD employer agency phone and e-mail</b>				
<b>SUPERVISOR:</b>	<b>At the time of this application, who is the direct supervisor of this DD personnel?</b>			
<b>Name &amp; Title: (print)</b>	Click here to enter text.			
<b>TELEPHONE:</b>	Click here to enter text.	<b>EMAIL:</b>	Click here to enter text.	
Date when supervisor began supervision of this DD Personnel?			Click here to enter a date.	
<b>PLEASE VERIFY ALL OF THE FOLLOWING ARE TRUE AS OF THE DATE OF THIS APPLICATION</b>				
<b>This person is employed by the agency:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Start Date:</b>	Click here to enter a date.
<b>This person is at least 18 years of age:</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>The agency has been provided documented proof of this person's high school diploma or equivalency?</b>			<input type="checkbox"/>	<input type="checkbox"/>
<b>All background check requirements have been completed according to OAC 5123:2-2-02 including results and registry checks within the specified time frames?</b>			<input type="checkbox"/>	<input type="checkbox"/>
<b><u>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 correct.</u></b>				
<b>Name &amp; Title of Agency Employer/Designee (print)</b>				
<b>Signature of Agency Employer/Designee</b>			<b>Date</b>	

# Ohio Department of Developmental Disabilities

## Application for DD Personnel Medication Administration Certification

**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.

**PAGE 2: MUST BE COMPLETED BY DD PERSONNEL**

<b>This application is for:</b>	Choose an item.							
Have you ever taken a medication administration certification class before this application?					Yes <input type="checkbox"/>	No <input type="checkbox"/>		
<b>Last Name:</b>	(print)	Click here to enter text.						
<b>First Name:</b>	(print)	Click here to enter text.		<b>Middle Initial:</b>	Click here to enter text.			
Last four digits of social security number: (not full number)			Click here to enter text.		<b>Date of Birth</b>	Click here to enter a date.		
<b>Gender</b>	<b>Female</b> <input type="checkbox"/>		<b>Male</b> <input type="checkbox"/>					
<b>Are you an Independent Provider?</b>			<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>		
<b>If yes, do you have?</b>	Choose an item.		<b>(must provide proof to RN Trainer)</b>					
<b>Personal Address:</b>		Click here to enter text.						
<b>City:</b>	Click here to enter text.		<b>State:</b>	Click here to enter text.		<b>Zip:</b>	Click here to enter text.	
<b>County:</b>	Click here to enter text.							
<b>Telephone:</b>	<b>Home:</b>	Click here to enter text.		<b>Work:</b>	Click here to enter text.		<b>Cell:</b>	Click here to enter text.
<b>Personal Email:</b>								
<b>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.</b>								
<b>At the time of this application, do you work for more than one DD employer?</b>			<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>		
<b>If YES, please print the names and Provider Number of all DD employers you currently work for:</b>								
<b>DD Employer:</b>		Click here to enter text.			<b>Provider #:</b>		Click here to enter text.	
<b>DD Employer:</b>		Click here to enter text.			<b>Provider #:</b>		Click here to enter text.	
<b>I Attest that all information provided on this application is true, current and correct.</b>								
<b>Signature of DD Personnel</b>				<b>Date</b>				
<b><u>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</u></b>								
<b>RN Trainer Signature (includes validation of HSD/GED for Independent Providers)</b>						<b>Date</b>		