

**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

\_\_\_\_\_  
Signature of Agency Employer/Designee      Date: \_\_\_\_\_

**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.

\_\_\_\_\_  
*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 # (If Initial Certification – not renewal)