Attestation of Certified Medication Aide Training Program Completion

Form A

Part 1 - General Information - Please Print

(Applicant must complete this part and send to the medication aide training program)

Legal Name_____
Last First Middle Maiden

Date of Birth_____Telephone Number_____
Month/Day/Year

Email Address_____

Signature_____Date_____

Part 2 - Attestation of Completion of Medication Aide Training Program - Please Print

(Medication aide training program must complete this part and send directly to the Board)

Program Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Program_____

This is to verify that the applicant named above successfully completed the above-named medication aide training program approved by the Ohio Board of Nursing.

Completion Date (Month/Day/Year): _____

This is to verify that the applicant named above successfully passed an examination demonstrating their ability to administer prescription medications safely.

☐ **Yes Passed Written Test Date** _____ **Passed Skill Test Date** _____

☐ **Testing to be administered by D&S Diversified Technologies**

Name of Registered Nurse Program Administrator (Print)	Title of Registered Nurse Program Administrator (Print)
Telephone Number of Registered Nurse Program Administrator	E-mail Address of Registered Nurse Program Administrator
Signature of Registered Nurse Program Administrator	Date

The Program Administrator must submit this completed form by email to medicationaides@Nursing.Ohio.gov.