

EMPLOYER FILLABLE AFFIDAVIT: MEDICATION CERTIFICATION APPLICATION FORM (Complete All Sections 1 thru 10)

This form has been approved by the DODD office of the Health Improvement & Policy Specialist 3/13/2018

CLEAR ALL



1. ENTER TRAINING DATE: 2. CLASS LOCATON: CINCINNATI XENIA Other Location Located at:

3. TRAINING CATEGORY Category 1 Initial Med Admin: ☐ Category 1 Renewal: ☐ Category 2 G/J Tube: ☐ Category 2 Renewal: ☐ Category 3 Insulin Admin: ☐ Category 3 Renewal: ☐

4. TIME **DO NOT ENTER ADDRESSES, PHONE NUMBERS OR EMAILS OF PERSONS BEING SERVED WHEN COMPLETING THIS FORM.**

5. EMPLOYER INFORMATION: Agency Name: Provider # Main /Parent Office Address (Enter full address):

Agency Main Phone # w/area code: Your Name: Your Phone # w/area code: Your Email:

Agency Located in What County? At which Location will employee receive or provide supervision? ☐ Main/Parent Office: **OR** ☐ Other Office Location (Branch Office) Other Phone: (If applicable) Other Email: (if applicable)

Address of Branch Office Location If applicable (Enter full address) : Branch Located in What County? Other Contact Name/Title (if applicable) :

6. ATTESTATION: As an authorized agency official, I attest that the listed individual (s) is/are currently employed by this agency and have met the eligibility requirements prior to enrolling in a DODD Category Certification or Re-Certification training including: evidence of HSD/GED, at least 18 years of age; results of Criminal Background Check (s) have been received; and he/she does/do not appear in any of the disqualifying database systems as listed in OAC 5123-2-2-02. By typing or signing my name in the adjacent space, I am attesting that all information entered on this form is true and accurate to the best of my knowledge.

*** Note:** Academy For Direct Support Professionals' Location addresses and Offerings can be viewed at the following link: <http://www.academy4dsp.com/classes-2/>



7. Name/ Title: 8. Date:

10. SUPERVISORY INFORMATION

For Duplicate entries, may enter Supervisor's First Name and use the word "SAME" for phone number & email address

*** ENTER THE START DATE THAT THE CURRENT SUPERVISOR WAS ASSIGNED TO EMPLOYEE AND/OR EMPLOYEE WORK LOCATION START DATE ONLY IF DIFFERENT FROM THE HIRE DATE.**

9. EMPLOYEE INFORMATION

	* DD PERSONNEL NAME	*LAST 4 SS#	* D.O.B.	*HIRE DATE	*DIRECT SUPERVISOR'S NAME/ PHONE / EMAIL
1	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
2	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
3	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
4	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
5	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
6	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>
7	<input type="text"/> LAST, FIRST MIDDLE INITIAL	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name: <input type="text"/> Phone: <input type="text"/> Email: <input type="text"/> Supervisory Start Date: <input type="text"/> Work Location Start Date: <input type="text"/>

ALL STAFF LISTED ON THIS PAGE ARE ASSOCIATED WITH THE SAME OFFICE BRANCH. USE A SEPARATE FORM FOR STAFF WORKING FROM OTHER BRANCH OFFICES.

To Submit Form, click on: ☐ (top left corner of form)