

2022

## Registration Form for Medication Administration Certification Classes/Renewals/Skills Checks

### Attendee Information

**\*Last Name, First Name:**

**\*Phone:**

**\*Email Address:**

**\*Agency/Independent Provider DODD Provider number:**

**\*Required Information.** An Employer Affidavit (Application), found on the HCBDD website under the "Provider" tab, must be submitted for registrants of these classes. (Agencies must complete an affidavit for their staff. Independent Providers must complete one for themselves.)

**Mark All Classes to Attend & Date(s) requesting:** Date(s): \_\_\_\_\_

Category 1 Initial Certification

Category 2 Initial Certification

Category 3 Initial Certification

Category 1 Renewal

Skills Checks

Category 2 Renewal

Skills Checks

Category 3 Renewal

Skills Checks

**Currently, classes are being offered FREE OF CHARGE**