



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, 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-\$90

_____ Category 2 Initial Certification-\$45

_____ Category 3 Initial Certification-\$45

_____ Category 1 Renewal-\$25

_____ Skills Checks-\$15

_____ Category 2 Renewal-\$12

_____ Skills Checks-\$15

_____ Category 3 Renewal-\$12

_____ Skills Checks-\$15

Total fee due: _____

FOR OFFICE USE ONLY: Amount & Date Paid: _____