



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

DISCOUNT for 3 or more from same agency: (Initial Certification) - Cat 1 \$75; Cat 2 & 3 \$35

Checks can be made payable to: HCBDD

_____ Category 1 Renewal-\$25

_____ Skills Checks-\$15

_____ Category 2 Renewal-\$12

_____ Skills Checks-\$15

_____ Category 3 Renewal-\$12

_____ Skills Checks-\$15

DISCOUNT for 3 or more from same agency: (Renewal) - Cat 1 \$20; Cat 2 & 3 \$10; skills checks \$10

Checks can be made payable to: HCBDD

Total fee due: _____ Discount: _____ Yes _____ No

FOR OFFICE USE ONLY: Amount & Date Paid: _____