

Community Care Alternatives, Inc.

419 East Perkins Avenue, Suite B.; Sandusky, Ohio 44870

Phone: 419-502-4663 or 1-866-235-5399

Fax: 419-502-4663

STUDENT REGISTRATION FORM

(CERTIFICATION COURSES FOR DD PERSONNEL)

All information must be completed for this Registration to be processed.

Date of Registration: _____

I am registering for:

- Certification I:** Medication Administration
- Certification II:** Tube Feeding
- Certification III:** Insulin Administration

Date(s) of Class that this Registration is for: _____

Name: _____

Date of Birth: ____ / ____ / ____

Social Security Number: _____

Have you taken this class before? YES NO Are you a high school graduate? YES (Diploma GED) NO

Are you a **DODD certified Independent Provider**? YES NO

If you checked "yes", please attach a copy of your **FINAL APPROVAL Letter** from DODD with this Registration Form.

For RN Trainer Use Only: Letter Received: YES NO

Current DD Employer: _____

Employer Address: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Immediate Supervisor or Director of Nursing: _____

Please check all areas that apply to your DD employment.

- Family Support
- Supported Living
- Certified Home- and Community-Based Provider
- Facility with 5 or fewer Beds
- Facility with 6-16 Beds
- Other: _____

DD Work Experience (Begin with present employer.)

Dates of Employment

Employer Name, Address, & Phone Number

Employer Statement:

Prior to permitting DD personnel to take the Medication Course, the employer of the DD personnel shall perform employee checks compliant with OAC 5123:2-6-06 (A) (1) (2), (B) (1) (2) (3). The following signature is indicative that these checks have been completed and that the applicant whose name appears above meets current eligibility requirements.

Employer's Name

Employer's Signature / Title