

**BLANCHARD VALLEY CENTER/HCBDD**  
**CERTIFICATION COURSES FOR DD PERSONNEL**  
**PARTICIPANT REGISTRATION AND ELIGIBILITY INFORMATION**

ALL INFORMATION MUST BE COMPLETED FOR THIS REGISTRATION TO BE PROCESSED

Date of Registration: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

I am registering for  Certification 1: Medication Administration

Certification 2: Tube Feeding

Certification 3: Insulin Injection

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 have checked YES, attach a copy of your FINAL APPROVAL letter from DODD with this registration or bring the letter to the first day of class. **List your FULL social security number above and include and email address here:**

\_\_\_\_\_

**For RN Trainer Use : Letter Rec'd**  Y  N

Current DD Employer:

\_\_\_\_\_

Employer Address:

\_\_\_\_\_

Work phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Immediate Supervisor (Please Print): \_\_\_\_\_

**Please check all areas that apply to your DD employment**

Family Supports

Facilities with 5 or fewer beds

Supported Living

Facilities with 6 – 16 beds

Certified home and Community Based Provider

Other \_\_\_\_\_

**DD Work Experience** (start with present employer)

Dates of Employment

Employer Name, Address, Phone Number

(continued on next page)

Dates of Employment

Employer Name, Address, Phone Number

**Employer Use**

Prior to permitting DD personnel to take the medication course, the employer of the DD personnel shall perform employee checks compliant to 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.

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Signature and Title

Directions for returning completed registration <b><u>by mail or fax:</u></b> <b>Mail to:</b>	Directions for returning completed registration <b><u>in person:</u></b> <b>Bring to:</b>
Michelle Darrach RN, Training Coordinator Blanchard Valley Center/HCBDD 1701 East Main Cross Findlay Ohio 45840 Phone: (419) 422-6387 ext 1219 Fax: (419) 425-7053	Dawn Webb Blanchard Valley Center/SSA Dept. 1700 East Sandusky Street Findlay, Ohio 45840 Phone: (419) 425-8747 Fax: (419) 425-8748