

Blanchard Valley Center

Medication Administration Course for MR/DD Workers

Trainee Information sheet

Trainee Name: _____ **SS#:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____ **D.O.B.:** _____

Address: _____

E-mail Address: _____

County Board of MR/DD: _____ **Immediate Supervisor:** _____

Work experience: (Start with present Employer)

Dates of Employment	Employer/Type of work	Employer Address	Phone Number

Education (circle one): Higher school diploma GED Years of Collage 1 2 3 4 degree _____

List Course Work completed beyond High School: _____

List special training or experience caring for individuals with MR/DD: _____

Have you taken this class before?(circle one) Yes No

If you have a qualifying disability according to the Americans with Disabilities Act, please list any necessary accommodations you will need while taking this course: _____
