CUYAHOGA COUNTY
Board of Developmental Disabilities

2018 MEDICATION ADMINISTRATION AND HEALTH-RELATED TRAINING PACKET

IMPORTANT:
Registration deadline is one week prior to class date.

EXTERNAL AGENCIES:
Registration is through Pages 5 - 7. Your registration is considered confirmed unless you receive a call to indicate otherwise.

IMPORTANT INFORMATION FOR ALL PARTICIPANTS:
In-Service training is a work activity. All workplace rules including those regarding cell phone use and all electronic devices are in effect during all training sessions. Please be courteous and respectful to the presenters and your fellow classmates by paying attention and participating.

Questions? Please Contact:

Madonna Hengoed, Staff Development Coordinator (216) 736-8352
hengoed.madonna@cuyahogabdd.org

PROGRAM INDEX

Medication Administration and Health-Related Activities
DODD Certification #1

CODE: DN6000-1

OBJECTIVES/PROGRAM CONTENT:
As a result of this program, participants will receive DODD certification to administer medications and perform specifically identified health-related activities according to laws and rules effective December 31, 2003. Instruction includes administration of oral, eye, ear, and nasal medications, medications administered via the topical route, and performance of health-related activities currently identified in law and rule, which may be performed by unlicensed personnel. This course is held over five days, four hours per day. Participants must be available to attend the entire session for all five days in order to receive certification.

PREREQUISITE: Prior to registering for this class, please consult with the nurse at your facility

CLASS LEVEL: This class is for initial certification

OPEN TO: CCBDD Employees *who do not* currently hold delegated nursing certification

CONTINUING EDUCATION: CCBDD 19 CPDU's (AS)

DATE	LOCATION	CODE	TRAINER	TIMES
May 7 – 9, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 4:30 PM
November 12 – 14, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 4:30 PM

EXTERNAL AGENCIES:
REGISTRATION IS THROUGH THE EXTERNAL REGISTRATION FORM AND MEDICATION ADMINISTRATION APPLICATION FOUND AT THE END OF THIS PACKET

William Patrick Day Services Center
2421 Community College Avenue
Cleveland, OH 44115

Administration of Tube Feeds and Medications via Tube
DODD Certification #2

CODE: DN6001-1

OBJECTIVES/PROGRAM CONTENT:
As a result of this program, participants will receive DODD certification to perform tube feedings and administer medications via gastrostomy tubes, jejunostomy tubes, and gastrostomy buttons. This is a new certification as a result of changes to DODD nursing law and rule effective December 31, 2003.

PREREQUISITES:

1. Prior to registering for this class, personnel must successfully complete criteria to obtain Certification #1: Medication Administration and Health-Related Activities.

2. Prior to registering for this class, CCBDD personnel must consult with the nurse at your facility.

CLASS LEVEL: This class is for initial certification.

OPEN TO: **DD personnel** who currently hold Certification #1: Medication Administration and Health-Related Activities.

CONTINUING EDUCATION: **CCBDD 5** CPDU's (AS)

DATE	LOCATION	CODE	TRAINER	TIME
May 23, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 12:30 PM
November 28, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 12:30 PM

EXTERNAL AGENCIES:

REGISTRATION IS THROUGH THE EXTERNAL REGISTRATION FORM AND MEDICATION ADMINISTRATION APPLICATION FOUND AT THE END OF THIS PACKET

William Patrick Day Services Center
2421 Community College Avenue
Cleveland, OH 44115

Medication Certification
DODD Certification #3

CODE: DN6031-1

OBJECTIVES/PROGRAM CONTENT: This is a required course for DD personnel who administers subcutaneous insulin to individuals with intellectual and developmental disabilities. As a result of this program, participants will learn signs and symptoms of Diabetes as well actions to take when there is any indication of adverse health events. Participants will also learn potential complications of Diabetes and Insulin.

PREREQUISITES:

1. Students must be employed in the DD field, either by a certified agency or as a DODD certified Independent Provider
2. Students must have a high school diploma or GED. This and completion of all background checks must be certified by employer by start date of class.
3. Students must have a valid DODD issued Medication Certification Level 1

OPEN TO: **DD personnel** who currently hold Certification #1: Medication Administration and Health-Related Activities

CONTINUING EDUCATION: **ODODD** 7.0 CPDU'S (AS)

DATE	LOCATION	CODE	TRAINER	TIME
May 24, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 4:30 PM
November 29, 2018	William Patrick Day *Conference Room D	WP	RN Instructor	8:15 AM – 4:30 PM

EXTERNAL AGENCIES:

REGISTRATION IS THROUGH THE EXTERNAL REGISTRATION FORM AND MEDICATION ADMINISTRATION APPLICATION FOUND AT THE END OF THIS PACKET

William Patrick Day Services Center
2421 Community College Avenue
Cleveland, OH 44115

EXTERNAL REGISTRATION

Please Print

Name: _____

Work Name: _____

Work Address: _____

City: _____ **State:** _____ **Zip:** _____

E-Mail Address: _____

Home Phone: _____ **Work Phone:** _____

Status (please check all that apply):

_____ **Volunteer** _____ **Respite** _____ **Transportation** _____ **Day Program**
_____ **Residential Staff** _____ **Other** _____
_____ **Parent/Guardian**
_____ **Name of Agency/Provider** _____

Please register me for the following programs:

Class Code:	Program:	Date:	Time:	Location Code:

Return this registration form to: Registration/Staff Development, CCBDD – Attn: Staff Development, 1275 Lakeside Ave East, Cleveland, OH 44114-1129

You may also fax to: 216-736-4544 (Attn: Staff Development) or E-Mail at: hengoed.madonna@cuyahogabdd.org

Registration is due one week prior to program date. Your registration is considered confirmed unless you receive a telephone call to indicate otherwise

If you find that you cannot attend the class after you registered for it, please cancel your registration ASAP by calling Madonna Hengoed at 216-736-8352 so that others may attend.

If you do not register for a class, you will not be able to participate. Participants that are not on the registration list will need to report back to their own work site.

Externalregistration2018

Cuyahoga County Board of Developmental Disabilities

APPLICATION TO ATTEND THE DODD MEDICATION ADMINISTRATION CERTIFICATION COURSE

Page 2: Must be fully completed by EMPLOYER

Information is required prior to Initial Certification or Renewal of DODD Medication Administration Certification.

DD Personnel: _____ **Date of Application:** _____

Agency Employer ☐ **OR Independent Provider** ☐ (if you are a DODD Independent Provider, for the purposes of this application, you are the employer)

Agency/Employer _____ **DODD Provider Number:** _____

Work Location – At the time of this application, where does the individual primarily provide services or supervision?

Address: _____

_____

Work Location Phone number: _____ Start date at this location: _____

Location or agency e-mail address: _____

Supervisor - At the time of this application, who is the direct supervisor of the DD personnel?

Name and Title of direct supervisor: _____

Phone number for direct supervisor_____ E-mail for direct supervisor: _____

When did this supervisor begin supervision of this DD personnel? Date: _____

Please verify that all of the following are true as of the date of this application:

- This person is employed by the agency ☐ YES Start Date: _____
- This person is at least 18 years of age ☐ YES
- The agency has been provided documented proof of this person's high school diploma or equivalency ☐ YES
- All background check requirements have been completed according to OAC 5123:2-2-02 including results and registry checks within the specified time frames ☐YES

For Independent Providers:

- Provide copy of final authorization letter to RN trainer (for initial certification)
- Provide copy of High School Diploma or GED to RN trainer

As the agency employer of the DD personnel or Independent Provider whose name appears on this application, I attest that all information provided on this application is accurate and current.

PRINT: _____

Name and Title of Agency Employer/Designee

SIGNATURE: _____ DATE: _____

Cuyahoga County Board of Developmental Disabilities

APPLICATION TO ATTEND THE DODD MEDICATION ADMINISTRATION CERTIFICATION COURSE

Page 1: Must be completed by DD Personnel

Application must be completed prior to Medication Administration Certification course. Without a completed application (including signatures and all applicable documentation), DD personnel will not be eligible for Medication Administration course.

This application is for:

Category 1 – Medication Administration ☐ Category 2 – G/J Tube Medication ☐ Category 3 – Insulin ☐

Category 1 – Renewal ☐ Category 2 – Renewal ☐ Category 3 – Renewal ☐

Have you ever taken a medication administration certification class before this application? ☐Yes ☐No

If "Yes" and this is not for renewal, please explain: _____

PRINT LEGIBLY ALL INFORMATION REQUESTED

Last *four* (4) digits of social security number: _____ _____ _____ _____ **Date of Birth:** _____/_____/_____

Last Name: _____ **Gender: ☐Female ☐Male**

First Name: _____ **Middle Initial:** _____

Phone #s Must provide at least one phone number

Home: (_____) _____ **Cell: (_____)**_____ **Work: (_____)** _____

Personal e-mail: _____@_____

Your certificates and renewal notices will be sent to you by e-mail.
*You **MUST** provide a non-work e-mail address where you will reliably receive messages*

Personal Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Are you an Independent Provider? ☐No ☐Yes If "Yes" complete the following:
Do you have a: ☐High School Diploma? or ☐High School Equivalency Document (GED)? **(Must provide copy to RN Trainer)**

At the time of this application, do you work for more than one DD employer? ☐No ☐Yes

If "yes" please print the names and provider number of all DD employers you currently work for:

DD Employer_____ **DD Provider #** _____

DD Employer_____ **DD Provider #** _____

DD Employer_____ **DD Provider #** _____

I attest that all information provided on this application is true, current, and correct.

_____ Date: _____

(Signature of DD Personnel)

For Initial Certification, return completed registration (both pages) prior to class by mail, fax, or e-mail to
Tamara M. Lentini, RN Nurse Educator, CCBDD
2421 Community College Avenue, Cleveland Ohio 44115
Phone: 216*736*4521 Fax: 216*736*3393 E-mail: Lentini.Tamara@cuyahogabdd.org

FOR RN TRAINER USE: (form to be kept in retrievable file, accessible to authorized personnel and DODD upon request for seven years)

_____ _____ _____

RN Trainer signature (includes verification of HSD/GED for Indep. Providers) Date Session # (initial certification only)