WHO: Registered nurses who:

- Are seeking initial training for DODD trainer certification to train DD personnel in the administration of medication and performance of nursing tasks
- Are seeking repeat training for DODD trainer re-certification
- Are seeking more information re: law and rule, training DD personnel in the administration of medication and performance of nursing tasks, the process of delegation, DODD MA database

Administrators, supervisors, SSAs and other non-nurses, as well as LPNs who:

- Are seeking more information re: law and rule, delegation, and medication administration and other activities as performed by DD personnel

WHAT: A train-the-trainer program, preparing registered nurses to train DD personnel to administer medications and perform health-related activities, administer tube feedings and medications, and/or perform insulin injections (Certification # 1, 2 and 3)

WHEN: Feb. 12 and 13, 2014, 8 a.m.-4:30 p.m.
May 14 and 15, 2014, 8 a.m.-4:30 p.m.
Oct. 1 and 2, 2014 8 a.m.-4:30 p.m.

WHERE: Cuyahoga County Board of Developmental Disabilities
Big Creek Center
6149 West 130th Street, Parma, OH 44130
Phone (216) 362-3777

HOW: In order to receive trainer certification, registered nurses must complete pre-class training assignment, attend both days of this program, complete written evaluations and complete and submit the post-program independent study assignment by the assigned deadlines. Further instructions will be given during this program.

Instructors: Patricia A. Higgins, RN, BSN, CCBDD Nurse Manager & Certified DODD Instructor of RNs and Trainer of DD Personnel

Kathy Biddlestone, RN, BSN, CDDN, CCBDD Infection Control/QA Nurse & Certified DODD Instructor of RNs and Trainer of DD Personnel.
Application to Attend RN Train-the-Trainer Certification Course

Prerequisites for Trainer Certification:
(These prerequisites are based on DODD Rule 5123:2-6-04 (B)(1)(a)(b) (c) and cannot be waived. If the applicant does not meet the criteria, please delay and register for another training at a time when the criteria will be met)

1. Current valid licensure in Ohio to practice as a registered nurse
2. A minimum of 18 months experience as a registered nurse
3. Previous experience caring for an individual with developmental disabilities

Registration: Fax or mail the completed application and $80.00 registration fee (check or money order payable to CCBDD)

Cuyahoga County Board of Developmental Disabilities
1275 Lakeside East
Cleveland, OH 44114
Fax: (216) 861-0253
Attn: Patti Higgins, RN

Parking: Free parking is available at the site. There are numerous hotels within a 3-mile radius.

Feel free to call for further details.

CE & Other Info:
1. Registration deadline is 1 week prior to start date of class.
2. Attendance is limited.
3. Registration is dependent upon receipt of application and payment and will be accepted upon a first-come, first-served basis. Registration is not confirmed until application has been approved and fee has been received.
4. Though only registered nurses may receive trainer certification, licensed practical nurses may attend this training and receive CE accordingly, but will not receive trainer certification. Administrators who are not nurses are welcome to attend, but no CE or trainer certification can be offered.

For questions or additional information, please contact:

Kathy Biddlestone, RN, BSN, CDDN biddlestone.kathleen@cuyahogbdd.org (216) 362-3715
Patty Higgins, RN, BSN higgins.patricia@cuyahogabdd.org (216) 736-2686
Page 1: Must be completed by RN trainer applicant
Application must be completed prior to RN trainer course. Without a completed application (including signatures and all applicable documentation), applicant will not be eligible for course participation as all requested information is required for MAIS entry. Payment must be received prior to start of class to ensure participation. Registration is not confirmed until application has been approved and fee has been received

PRINT LEGIBLY ALL INFORMATION REQUESTED

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<tr>
<th>RN License Number</th>
<th>Date of Issue</th>
<th>State of Issue</th>
<th>Gender</th>
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<td>RN _____________</td>
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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: __________________________________________________________

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Are you self-employed? ☐ No ☐ Yes If “Yes” complete the following:

Date Self-Employed Status Began: ______/_______/_______

Current Employer: __________________________________________________________ DD Provider #: _______________________

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Employment Start Date (month, day & year required): ______/_______/_______

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督导者名称: ____________________________   ________________________________   Phone: _________________________

Date supervision began: (month, day & year required): ______/_______/_______

Work Location address (if different from agency mailing address):

(street)                  (city)        (state)  (zip)  (county)

Work Location Start Date (month, day & year required): ______/_______/_______

RN/DD WORK EXPERIENCE INFORMATION
(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)

Employer: ___________________________________________ RN Experience: ☐  DD Experience: ☐

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Employment End Date (month, date and & year required): ______/_______/_______

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督导者名称: ____________________________   ________________________________   Phone: _________________________

(last)        (first)
Application to Attend RN Train-the-Trainer Certification Course

Supervisor’s E-mail: __________________________________________________________
Title: ______________________________________________________________________
Role/Duties: __________________________________________________________________________

ICF/DD □ Self-Employed □ DODD Agency Provider □

(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)
Employer: ____________________________________________________________
Agency Address (street number/city/state/zip): ________________________________
Agency Phone: ___________________________ Agency Email: ________________________________
Employment Start Date (month, day & year required): ______/_______/________
Employment End Date (month, date and & year required): ______/_______/________
Supervisor’s Name: ___________________________ Phone: ________________________________
(last) (first)
Supervisor’s E-mail: __________________________________________________________
Title: ______________________________________________________________________
Role/Duties: __________________________________________________________________________

ICF/DD □ Self-Employed □ DODD Agency Provider □

(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)
Employer: ____________________________________________________________
Agency Address (street number/city/state/zip): ________________________________
Agency Phone: ___________________________ Agency Email: ________________________________
Employment Start Date (month, day & year required): ______/_______/________
Employment End Date (month, date and & year required): ______/_______/________
Supervisor Name: ___________________________ Phone: ________________________________
(last) (first)
Supervisor’s E-mail: __________________________________________________________
Title: ______________________________________________________________________
Role/Duties: __________________________________________________________________________

ICF/DD □ Self-Employed □ DODD Agency Provider □

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

_________________________________________ Date: ___________________________
(Signature of RN Trainer Applicant)

Return completed registration (both pages) and $80 registration fee prior to class by mail, fax 216.861.0253 or e-mail to:
CCBDD 1275 Lakeside Avenue, Cleveland Ohio 44114 Attn: Patti Higgins, RN (higgins.patricia@cuyahogabdd.org)