Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

Attestation of Dialysis Technician Training Program Completion

Form A

Part 1-General Information-Please Print

(Applicant must complete this part and send to the dialysis technician training program)

Full Legal Name_____
Last First Middle Maiden

Date of Birth _____ Telephone Number_____
Month / Day / Year

Email Address_____

Signature_____Date_____

Part 2-Attestation of Completion of Dialysis Technician Training Program-Please Print

(*Dialysis training program must complete this part and send directly to the Board)*

Program Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Program_____

This is to verify that the applicant named above enrolled in and has successfully completed an approved dialysis training program as defined below:

A "dialysis training program" means a program approved by the board according to rule 4723-23-07 of the Administrative Code that consists of not less than three hundred twenty clock hours of instruction including both of the following:

(1) A minimum of one hundred clock hours of theoretical instruction in a classroom setting; and
(2) A minimum of two hundred twenty clock hours of supervised clinical experience

_____
Date of Enrollment (Month/Day/Year)

_____
Date of Completion (Month/Day/Year)

_____ _____
Name of Registered Nurse Program Administrator | Title of Registered Nurse Program Administrator

_____ _____
Telephone Number of Registered Nurse Program Administrator | E-mail Address of Registered Nurse Program Administrator

_____ _____
Signature of Registered Nurse Program Administrator | Date

The Program Administrator may submit this completed form by email to dialysis@nursing.ohio.gov, by fax at (614) 466-0388, or by mail to: Ohio Board of Nursing, Attention: DT, 17 South High Street, Suite 400, Columbus, OH 43215-7410.

First Name Last Name (Applicant-Please Print Clearly)

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Attestation of Dialysis Technician Competency & Employment

Form B

Part 1-General Information-Please Print ***(Applicant must complete this part and send to the dialysis employer)***

Full Legal Name_____
Last First Middle Maiden

Date of Birth _____ Telephone Number_____
Month / Day / Year

Email Address_____

Signature_____Date_____

Part 2-Dialysis Attestation-Please Print (***Dialysis employer must complete this part and send directly to the Board)***

Employer Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Employer _____

This is to verify that a registered nurse or licensed physician observed the applicant named above perform dialysis care and to attest that the applicant consistently performs dialysis care in accordance with the standards for the safe performance of dialysis care as set forth in Rule 4723-23-12 and Rule 4723-23-14 of the Administrative Code.

_____
Employment Start Date (Month/Day/Year)

_____
Employment End Date (Month/Day/Year)

Name of Person Completing Part 2 | Title of Person Completing Part 2

Telephone Number of Person Completing Part 2 | E-mail Address of Person Completing Part 2

Signature of Person Completing Part 2 | Date

Dialysis Employer may submit this completed form by email to dialysis@nursing.ohio.gov, by fax at (614) 466-0388, or by mail to: Ohio Board of Nursing, Attention: DT, 17 South High Street, Suite 400, Columbus, OH 43215-7410.

2015 Dialysis

First Name Last Name (Applicant-Please Print Clearly)

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Verification of Passing BONENT or NNCO Certification Examination

Form C

Part 1-General Information-Please Print

(*Applicant must complete this part and send to the national testing organization)*

Form C must be submitted to BONENT or NNCO at the time of registration to take the national certification examination OR if you have already taken the examination, at the time of application to the Board.

Applicant Name_____

Date of Birth _____ Telephone Number_____
Month / Day / Year

Address_____

City_____State_____Zip_____County_____

Email_____

Name of Dialysis Technician Training Program (Completed)_____

City and State of Dialysis Technician Training Program (Completed)_____

I authorize the national testing organization to provide information to the Ohio Board of Nursing regarding my certification examination results.

Signature_____Date_____

Part 2- Testing/Certification Information-Please Print

(BONENT or NNCO representative must complete this part and send directly to the Board Attention: DT)

Name of Testing Organization_____

Address_____

City_____State_____Zip_____

Telephone Number _____

I certify that the above named applicant passed a national certification examination demonstrating competence to perform dialysis care.

Name of Person Completing Part 2 (Print) | Month/Day/Year of Certification

Title of Person Completing Part 2 (Print) | Signature of Person Completing Part 2

Telephone Number of Person Completing Part 2 | Date

BONENT or NNCO Representative may submit this completed form by email to dialysis@nursing.ohio.gov, by fax at (614) 466-0388, or by mail to: Ohio Board of Nursing, Attention: DT, 17 South High Street, Suite 400, Columbus, OH 43215-7410.

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Application for Dialysis Technician Performance Verification

Form D

Applicant must have performed dialysis for ***not less than 12 months immediately prior*** *to the date of this OCDT application.*

Part 1-General Information-Please Print ***(Applicant must complete this part and send to the dialysis employer)***

Full Legal Name_____
Last First Middle Maiden

Date of Birth _____ Telephone Number_____
Month / Day / Year

Address_____

City_____State_____Zip_____County_____

Email_____

Signature_____Date_____

Part 2-Dialysis Attestation-Please Print (***Dialysis employer must complete this part and send directly to the Board)***

Employer Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Employer _____

This is to verify that the applicant named above has performed dialysis care for not less than 12 months immediately prior to the date of this application.

_____
Employment Start Date (Month/Day/Year)

_____
Employment End Date (Month/Day/Year)

_____ _____
Name of Person Completing Part 2 Title of Person Completing Part 2

_____ _____
Telephone Number of Person Completing Part 2 E-mail Address of Person Completing Part 2

_____ _____
Signature of Person Completing Part 2 Date

Dialysis Employer may submit this completed form by email to dialysis@nursing.ohio.gov, by fax at (614) 466-0388, or by mail to: Ohio Board of Nursing, Attention: DT, 17 South High Street, Suite 400, Columbus, OH 43215-7410.