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

Attestation of Medication Aide Training Program Completion

Form A

Part 1-General Information-Please Print

(Applicant must complete this part and send to the medication aide training program)

Full Legal Name_____
Last First Middle Maiden

Social Security Number*_____

Telephone Number_____ Email Address_____

Signature_____Date_____

Part 2-Attestation of Completion of Medication Aide Training Program -Please Print

(Medication aide 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 successfully completed the above named medication aide training program on:

_____
Date of Completion (Month/Day/Year)

_____
Name of Registered Nurse Program Administrator (Print)

_____
Title of Registered Nurse Program Administrator (Print)

_____
Telephone Number of Registered Nurse Program Administrator

_____
Signature of Registered Nurse Program Administrator Date

*Your social security number is required by state law and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60), reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

Please submit this form to: Ohio Board of Nursing, Attention: Medication Aide, 17 South High Street, Suite 400, Columbus, OH 43215-7410 OR Fax to (614) 466-0388.

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