Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 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)

Legal Name_____
Last First Middle Maiden

Date of Birth_____Telephone Number_____
Month/Day/Year

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 approved by the Ohio Board of Nursing.

_____
Completion Date (Month/Day/Year)

Name of Registered Nurse Program Administrator (Print)

Title of Registered Nurse Program Administrator (Print)

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 medicationaides@nursing.ohio.gov or by Fax to (614) 466-0388 or mail "Attention MA-C" to the address above.