



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)

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 Ohio approved dialysis training program.

Enrollment Date (Month/Day/Year)

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



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)

Legal Name Last First Middle Maiden

Date of Birth Month/Day/Year Telephone Number

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 (Print)

Title of Person Completing Part 2 (Print)

Telephone Number of Person Completing Part 2

E-mail Address of Person Completing Part 2

Signature of Person Completing Part 2

Date

The Dialysis Employer may submit this completed form by email to dialysis@nursing.ohio.gov or by Fax to (614) 466-0388 or mail "Attention DT" to the address above.



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.

Legal Name Last First Middle Maiden

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)

Testing Organization Name

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 or by Fax to (614) 466-0388 or mail "Attention DT" to the address above.



Application for Dialysis Technician Performance Verification Form D

Applicant must have performed dialysis care for not less than 6 months immediately prior to the date of this DT application.

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

Legal Name Last First Middle Maiden

Date of Birth Month/Day/Year Telephone Number

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 Program

This is to verify that the applicant named above has performed dialysis care for not less than 6 months immediately prior to the date of this application.

Employment start date AND employment end date lines MUST have a date. If a line is left blank, Form D will be void.

Employment Start Date (Month/Day/Year) Required

Employment End Date (Month/Day/Year) Required

Name of Person Completing Part 2 (Print)

Title of Person Completing Part 2 (Print)

Telephone Number of Person Completing Part 2

E-mail Address of Person Completing Part 2

Signature of Person Completing Part 2

Date

The Dialysis Employer may submit this completed form by email to dialysis@nursing.ohio.gov or by Fax to (614) 466-0388 or mail "Attention DT" to the address above.