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.