Ohio Board of Nursing

www.nursing.ohio.gov

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 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)

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 <u>directly</u> 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.

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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)

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 <u>directly</u> 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.

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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.

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.

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Application for Dialysis Technician Performance Verification
Form D

Applicant must have performed dialysis care for <u>not less than 6 months immediately prior</u> 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______________________ 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 <u>directly</u> 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 <u>not less than 6 months immediately prior</u> to the date of this application.

Employment start date AND employment end date lines <u>MUST</u> 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.