



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
 DIVISION OF DEVELOPMENTAL DISABILITIES
MEDICATION AIDE 2 YEAR UPDATE TRAINING

NAME	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -
ADDRESS	MMEDICATION CERTIFICATE CERTIFICATE # _____ DATE ISSUED ____/____/____ SOURCE: (CHECK ONE): <input type="checkbox"/> DHSS (Formally DOA) <input type="checkbox"/> DD TYPE: (check one): <input type="checkbox"/> MEDICATION AIDE <input type="checkbox"/> CERTIFIED MEDICATION TECHNICIAN (CMT) <input type="checkbox"/> CERTIFIED MEDICATION EMPLOYEE (CME)	
EMPLOYER NAME	EMPLOYER ADDRESS	
A. Training shall address at least the following	DATE OF TRAINING ____/____/____ HOURS COMPLETED _____	DATE OF TRAINING ____/____/____ HOURS COMPLETED _____
1. Medication ordering and storage		
2. Medication administration		
<input type="checkbox"/> Use of generic drugs		
<input type="checkbox"/> How to pour, chart, administer and document		
<input type="checkbox"/> Information and techniques specific to the following: inhaler, eye drops, topical medications and suppositories		
<input type="checkbox"/> Infection Control		
<input type="checkbox"/> Side effects and adverse reactions		
<input type="checkbox"/> Medication errors		
3. Individual rights, and refusal of medications and treatments;		
4. Issues specific to the facility/program as indicated by the needs of the residents/clients, and the medications and treatments currently being administered		
5. Corrective actions based on problems identified by the staff, the trainees or issues identified by regulatory and accrediting bodies, professional consultants or by any other authoritative source; and		
Other specify:		
<p>The training shall be taken in two (2) two (2) hour blocks or a four (4) hour block. Medication aides who do not participate in at least 4 hours of medication administration training every two years will not be allowed to administer medication in accordance with 9CSR 45-3.060. A signed copy of this form denotes compliance with the training requirement. The form must be included in the employee's personnel file and copied to the regional center. It is the responsibility of the agency to offer and the employee to participate in the required training.</p>		
RN/LPN SIGNATURE (INSTRUCTOR)	LICENSE NUMBER	DATE
EMPLOYEE SIGNATURE		DATE