

**Division of Early Childhood Development  
Office of Child Care - Licensing Branch**

**Medication Administration Instructor Application**

*For OCC Use Only*

*Date Attended Orientation* \_\_\_\_\_ *Application Approved* \_\_\_\_\_ *Yes* \_\_\_\_\_ *No* \_\_\_\_\_

*By* \_\_\_\_\_ *Date* \_\_\_\_\_

*Nurse Consultant*

*Trainer Approval #* \_\_\_\_\_ *Date Assigned* \_\_\_\_\_

**Name** \_\_\_\_\_ **MBON-RN#** \_\_\_\_\_ **Exp** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

**Address** \_\_\_\_\_

*Street*

*City*

*State*

*Zip code*

**Education**

<b>School</b>	<b>Years Attended</b>	<b>Degree/Certification</b>

**Please summarize any experience, skills, and/or training that you feel makes you a good candidate to teach Medication Administration to adults.**

---



---



---



---



---

*By submitting this application, I affirm that the facts set forth are true and complete. I understand the roles and responsibilities of a medication administrator instructor and will abide by the Office of Child Care's Medication Administration Training Guidance and Standards.*

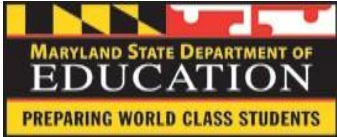
*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

Application may be mailed to:

MSDE, DECD Office of Child Care, Licensing Branch  
200 W. Baltimore Street, Baltimore, MD 21201  
ATTN: Nurse Consultant

MSDE OCC 06-07-2016

*MAT Application April 2016 (replaces all previous editions)*



**Division of Early Childhood Development  
Office of Child Care - Licensing Branch  
Medication Administration Training Plan**

Name \_\_\_\_\_ MBON-RN# \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Training will be offered in the following counties (*include locations if known*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Day Hours \_\_\_\_\_ to \_\_\_\_\_ and/or  Evening Hours \_\_\_\_\_ to \_\_\_\_\_

Application Process/How to Register for a Class: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fee Structure: \_\_\_\_\_  
\_\_\_\_\_

Methods of Payment Accepted: \_\_\_\_\_  
\_\_\_\_\_

Refund Policy: \_\_\_\_\_  
\_\_\_\_\_

Cancellation Policy (by Trainer and Participant): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

“No Show” Rescheduling Policy: \_\_\_\_\_  
\_\_\_\_\_

Advertising Methods: \_\_\_\_\_  
\_\_\_\_\_

Sample Training Certificate  Attached  Will submit prior to 1<sup>st</sup> scheduled training session.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail the training plan with the application to:

MSDE, DECD Office of Child Care, Licensing Branch  
200 W. Baltimore Street, Baltimore, MD 21201  
ATTN: Nurse Consultant