



STATE OF MISSOURI
 DEPARTMENT OF HEALTH AND SENIOR SERVICES
LEVEL I MEDICATION AIDE BIENNIAL TRAINING

EMPLOYEE NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER		
EMPLOYEE ADDRESS		CERTIFICATION INFORMATION DATE ISSUED ___/___/___ CERT #			
TRAINING AGENCY NAME					
TRAINING AGENCY ADDRESS					
TRAINING SHALL ADDRESS THE FOLLOWING:		DATE OF TRAINING	HRS COMPLETED	DATE OF TRAINING	HRS COMPLETED
<input type="checkbox"/> A. Medication ordering and storage; <input type="checkbox"/> B. Medication administration and documentation; <input type="checkbox"/> C. Use of generic drugs; <input type="checkbox"/> D. Infection Control; <input type="checkbox"/> E. Observing and reporting possible medication reactions; <input type="checkbox"/> F. New medications and/or new procedures; <input type="checkbox"/> G. Medication errors; <input type="checkbox"/> H. Individual rights, and refusal of medications and treatments; <input type="checkbox"/> I. Issues specific to the facility/program as indicated by the needs of the residents and the medications and treatments currently being administered; <input type="checkbox"/> J. Corrective actions based on identified problems.					
OTHER					
<p>The training shall consist of a minimum of four (4) hours and must be completed by the anniversary date of the Level I Medication Aide's initial certification. Level I 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 19 CSR 84.030. A signed copy of this form denotes compliance with the training requirement and must be included in the employee's personnel file.</p>					
<p>Submit this form by mail to the Dept of Health and Senior Services, Health Education Unit, PO Box 570, Jefferson City, MO 65102 or by fax to 573-526-7656. or email to cnaregistry@health.mo.gov</p>					
<p>We, the undersigned, hereby verify that the following student has successfully completed the Level I Medication Aide course of instruction and have satisfactorily passed the examination to qualify for certification meeting all requirement of Missouri 19 CSR 30-84.030.</p>					
RNLPN INSTRUCTOR SIGNATURE		LICENSE #	DATE		
EMPLOYEE SIGNATURE			DATE		
TRAINING AGENCY ADMINISTRATOR/OWNER/OPERATOR SIGNATURE			DATE		