

**The Alpha Group Inc.**  
**MEDICATION COURSE FOR DD Providers**  
**TRAINEE INFORMATION SHEET**

Trainee Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
Street city zip

Attach County Board of DD Final Approval Letter for Independent providers or Agency Document with provider number and employer signature below.

\*\*\*The employee named below has been checked and is in current compliance with OAC 5123:2-6-06 (A) (1) (2), (B) (1) (2) (3). \*\*\*

\_\_\_\_\_  
Employees Name Employers Signature Date  
Name of Employer and Immediate Supervisor

Work Experience (Start with present employer)

Dates of Employment	Employer	Type of Work
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:  
High School diploma or equivalent (check one): Graduated high school \_\_\_ GED \_\_\_

List any course work completed beyond high school:

\_\_\_\_\_

Have you had any special training or experience in the care of individuals with MR/DD?  
Yes \_\_\_ No \_\_\_ If yes, please describe:

Have you taken this class before? Yes \_\_\_ No \_\_\_

If you have a qualifying disability according to the Americans with Disabilities Act, please list any necessary accommodations you will need while taking this course.

\*\*\*\*\*

For Instructor's Use Only:

Abuser registry check done?

Nurse Aid Registry check done?

Results of Checks:

