Form OPWDD 811

# Medication Administration Course
# Certificate/Recertification Record

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|---|---|
| **Participant's Name** | **Social Security #** |
| **Agency Name & Address** | **Phone # (Include area code_** |
| **Employment Address** | **Phone # (Include area code)** |

**Participant has obtained a test score of 80% or above based on the medication administration course held at:**

**Location _____ Date _____**

**Instructor _____Signature _ _____**
**(Registered Nurse – Please Print)**

**Co-Instructor _____ Signature _____ _____**

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**Clinical Practicum**

**_____has completed three errorless performances including pouring,**
**Participant's Name (Print)**
**administering, and the recording, and the demonstrated knowledge of medications (their classification, intended action, side effects) and is certified to administer medications for one year from:**

**_____ to _____**
**Date Date**

**_____ _____ _____**
**Instructor's Name (Print) Signature Date**

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**Recertification: Required Yearly**

**Directions: The following areas should be addressed by a registered nurse who will complete the yearly recertification.**

- **Update on medications**
- **Update on policy**
- **Review of vital signs (Intermediate Care Facilities)**
- **Review of charting and five rights**
- **Observation of one errorless medication administration procedure**

| Name (Please Print) | Signature | Date |
|---|---|---|
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**Copies to: Participant/Instructor/Staff Development Office**