DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

TRAINED MEDICATION AIDE EMPLOYMENT ATTESTATION

PART 1: To be completed by the applicant.

NAME (Last, First, Middle)	Date of Birth (MM/DD/YYYY)
Social Security Number	TME License number
Name and Address of Employment	Employer's Phone Number and Email address

PART 2: To be completed by the supervising nurse. Pursuant to 17 DCMR § 6107, I, this applicant's supervising registered nurse (R.N.), confirm that this Trained Medication Employee, has maintained continuous adequate performance.

I hereby attest that the information provided is true to the best of my knowledge.

Supervising Nurse (Print name)	Supervising Nurse License No. / State (ex. RN1234 / DC)
Supervising Nurse Signature	Date

Knowingly making a false statement on this form is a violation of D.C. Official Code § 22-2405(b) and may lead to criminal penalties.