DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

THIS FORM MUST BE COMPLETED BY AN APPROVED DC TME INSTRUCTOR

I confirm this applicant has successfully completed training for a Trained Medication Employee Certification in the District of Columbia:

_____ _____

Name of TME Applicant Training Completion Date

By signing this attestation, I, _____, RN as the DC Trainer hereby
[Print Name]

attest that the information that I have provided on this TME Attestation of Training Form is true and complete to the best of my knowledge. Making a false statement on this document, including all writings and attachments, may result in the Department of Health taking action as it deems appropriate.

_____ _____

RN Signature Date

DC License No. _____