DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

District of Columbia Board of Nursing

TRAINED MEDICATION EMPLOYEE (TME)

REINSTATEMENT ATTESTATION

NAME OF TME	**TME NUMBER**
NAME OF EMPLOYER	**EMPLOYER'S ADDRESS**
NAME OF SUPERVISING RN	**RN NUMBER**

I, this APPLICANT'S SUPERVISING NURSE, confirm that to the best of my knowledge, this TME applicant is competent to administer medications: __ Yes ___ No

By signing this attestation, I, _____, RN as the Supervising Nurse hereby
[Print Name]

attest that the information provided on this Trained Medication Employee Attestation form is true and complete to the best of my knowledge. I understand that making a false statement on this document may result in the Board of Nursing taking any actions against my license as is deemed appropriate.

_____ _____

RN Signature **Date**