DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

TRAINED MEDICATION EMPLOYEE CLINICAL EXPERIENCE FORM

PART 1: To be completed by the applicant

NAME (Last, First, Middle)	Date of Birth (MM/DD/YYYY)
Social Security Number	Name and Address of Employer
Employer's No. and Email address	Job Title/Position (check one) Direct Support Professional ____ Home Health Aide____ Nursing Assistant ____ Medication Tech _____
Hire Date	End Date

PART 2: To be completed by the applicant. If not employed with the above employer for at least one (1) year, complete the section below.

Name and Address of Employment	Employer's No. and Email address
Hire date	End date
Job Title/Position	

PART 3: To be completed by the supervising nurse. I, this applicant's supervising nurse confirm that the person is competent to administer medication. I hereby attest that the information provided is true to the best of my knowledge. Making a false statement may result in DC HEALTH taking action that it deems appropriate.

Supervising Nurse (Print name)	Supervising Nurse License state and No.
Supervising Nurse Signature	Date