STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

LEVEL I MEDICATION AIDE BIENNIAL TRAINING

EMPLOYEE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

EMPLOYEE ADDRESS	CERTIFICATION INFORMATION DATE ISSUED ____/____/____ CERT #

TRAINING AGENCY NAME

TRAINING AGENCY ADDRESS

TRAINING SHALL ADDRESS THE FOLLOWING:	DATE OF TRAINING	HRS COMPLETED	DATE OF TRAINING	HRS COMPLETED
☐ A. Medication ordering and storage;				
☐ B. Medication administration and documentation;				
☐ C. Use of generic drugs;				
☐ D. Infection Control;				
☐ E. Observing and reporting possible medication reactions;				
☐ F. New medications and/or new procedures;				
☐ G. Medication errors;				
☐ H. Individual rights, and refusal of medications and treatments;				
☐ I. Issues specific to the facility/program as indicated by the needs of the residents and the medications and treatments currently being administered;				
☐ J. Corrective actions based on identified problems.				

OTHER

The training shall consist of a minimum of four (4) hours and must be completed by the anniversary date of the Level I Medication Aide's initial certification. Level I Medication Aides who do not participate in at least 4 hours of medication administration training every two years will not be allowed to administer medication in accordance with 19 CSR 84.030. A signed copy of this form denotes compliance with the training requirement and must be included in the employee's personnel file.

Submit this form by mail to the Dept of Health and Senior Services, Health Education Unit, PO Box 570, Jefferson City, MO 65102 or by fax to 573-526-7656.

We, the undersigned, hereby verify that the following student has successfully completed the Level I Medication Aide course of instruction and have satisfactorily passed the examination to qualify for certification meeting all requirement of Missouri 19 CSR 30-84.030.

RN/LPN INSTRUCTOR SIGNATURE	LICENSE #	DATE

EMPLOYEE SIGNATURE	DATE

TRAINING AGENCY ADMINISTRATOR/OWNER/OPERATOR SIGNATURE	DATE