MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

# APPLICATION FOR APPROVAL AS A CERTIFIED MEDICATION TECHNICIAN TRAINING AGENCY

This form is to be filled out by the school. Please type or print all information. Return to the Division of Regulation and Licensure, Health Education Unit, P.O. Box 570, Jefferson City, MO 65102, or fax to 573-526-7656.

| | | |
|---|---|---|
| ☐ NEW APPLICATION ☐ REVISED APPLICATION (Must submit if clinical or classroom sites change) | | CERTIFYING AGENCY |
| SPONSORING EDUCATIONAL AGENCY (SCHOOL) | | PHONE |
| ADDRESS (SCHOOL) | | FAX |
| INSTRUCTOR NAME | SOCIAL SECURITY NUMBER | LICENSE NUMBER |
| EXAMINER NAME | SOCIAL SECURITY NUMBER | LICENSE NUMBER |
| CLINICAL SUPERVISOR (IF APPLICABLE) | SOCIAL SECURITY NUMBER | LICENSE NUMBER |

DESCRIBE EQUIPMENT AND SPACE FOR CLASSROOM AND TEACHING AIDS INCLUDING THE FOLLOWING:

☐ MEDICATION CART

☐ HAND WASHING FACILITIES

☐ BUBBLE CARD PACKAGES OR MED-ADMINISTRATION SYSTEM

☐ STATE APPROVED MANUAL

☐ STATE APPROVED REGULATION BOOK

☐ VITAL SIGNS EQUIPMENT

☐ DRUG REFERENCE MANUAL

☐ DRUG MEASURING DEVICES

NAMES OF FACILITIES WITH WHICH THERE IS/ARE A SIGNED AGREEMENT(S) FOR CLINICAL ON-THE-JOB TRAINING. (ATTACH A COPY OF THE CURRENT AGREEMENT FOR EACH CLINICAL SITE.)

| | | |
|---|---|---|
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |

NAMES OF FACILITIES WITH WHICH THERE IS/ARE A SIGNED AGREEMENT TO PROVIDE A CMT CLASS (THEORY, CLINICAL AND EXAM) AT THEIR ADDRESS. (ATTACH A COPY OF THE CURRENT AGREEMENT FOR EACH CLASSROOM SITE.)

| | | |
|---|---|---|
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |
| FACILITY NAME | ADDRESS, CITY, ZIP | TELEPHONE |

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|---|---|
| **SIGNATURE (SCHOOL PROGRAM DIRECTOR)** | **DATE** |

IF ANY OF THESE SIGNED AGREEMENTS ARE TERMINATED PLEASE ALERT THE HEALTH EDUCATION UNIT BY ADDRESS OR FAX STATED ABOVE.