CUYAHOGA COUNTY
Board of Developmental Disabilities

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WHO: **Registered nurses who:**

- Are seeking initial training for DODD trainer certification to train DD personnel in the administration of medication and performance of nursing tasks
- Are seeking repeat training for DODD trainer re-certification
- Are seeking more information re: law and rule, training DD personnel in the administration of medication and performance of nursing tasks, the process of delegation, DODD MA database

Administrators, supervisors, SSAs and other non-nurses, as well as LPNs who:

- Are seeking more information re: law and rule, delegation, and medication administration and other activities as performed by DD personnel

WHAT: A train-the-trainer program, preparing registered nurses to train DD personnel to administer medications and perform health-related activities, administer tube feedings and medications, and/or perform insulin injections (Certification # 1, 2 and 3)

WHEN: **Feb. 12 and 13, 2014, 8 a.m.-4:30 p.m.**

May 14 and 15, 2014, 8 a.m.-4:30 p.m.

Oct. 1 and 2, 2014 8 a.m.-4:30 p.m.

WHERE: Cuyahoga County Board of Developmental Disabilities
Big Creek Center
6149 West 130th Street, Parma, OH 44130
Phone (216) 362-3777

HOW: In order to receive trainer certification, registered nurses must complete pre-class training assignment, attend **both** days of this program, complete written evaluations and complete **and submit the post-program independent study assignment by the assigned deadlines**. Further instructions will be given during this program.

Instructors: Patricia A. Higgins, RN, BSN, CCBDD Nurse Manager & Certified DODD Instructor of RNs and Trainer of DD Personnel

Kathy Biddlestone, RN, BSN, CDDN, CCBDD Infection Control/QA Nurse & Certified DODD Instructor of RNs and Trainer of DD Personnel.

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Application to Attend RN Train-the-Trainer Certification Course

Prerequisites for Trainer Certification:
(These prerequisites are based on DODD Rule 5123:2-6-04 (B)(1)(a)(b) (c) and cannot be waived. If the applicant does not meet the criteria, please delay and register for another training at a time when the criteria will be met)

1. Current valid licensure in Ohio to practice as a registered nurse
2. A minimum of **18 months experience as a registered nurse**
3. Previous experience caring for an individual with developmental disabilities

Registration: **Fax or mail** the completed application and $80.00 registration fee (check or money order payable to CCBDD)

Cuyahoga County Board of Developmental Disabilities
1275 Lakeside East
Cleveland, OH 44114
Fax: (216) 861-0253
Attn: Patti Higgins, RN

Parking: Free parking is available at the site. There are numerous hotels within a 3-mile radius.

Feel free to call for further details.

CE & Other Info:

1. **Registration deadline is 1 week prior to start date of class.**
2. Attendance is limited.
3. Registration is dependent upon receipt of application and payment and will be accepted upon a first-come, first-served basis. Registration is not confirmed until application has been approved and fee has been received.
4. Though only registered nurses may receive trainer certification, licensed practical nurses may attend this training and receive CE accordingly, but will not receive trainer certification. Administrators who are not nurses are welcome to attend, but no CE or trainer certification can be offered.

For questions or additional information, please contact:

Kathy Biddlestone, RN, BSN, CDDN biddlestone.kathleen@cuyahogbdd.org (216) 362-3715

Patty Higgins, RN, BSN higgins.patricia@cuyahogabdd.org (216) 736-2686

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Page 1: Must be completed by RN trainer applicant

Application must be completed prior to RN trainer course. Without a completed application (including signatures and all applicable documentation), applicant will not be eligible for course participation as all requested information is required for MAIS entry. Payment must be received prior to start of class to ensure participation. Registration is not confirmed until application has been approved and fee has been received

PRINT LEGIBLY ALL INFORMATION REQUESTED

RN License Number : RN _____ _____ Date of Issue: _____/_____/_____ State of Issue: : ____/_____/_____

Last Name: _____ Gender: ☐Female ☐Male

First Name: _____ Middle Initial: _____

Phone #s Must provide at least one phone number

Home: (_____) _____ Cell: (_____)_____ Work: (_____) _____

Personal e-mail: _____@_____

Your certificates and renewal notices will be sent to you by e-mail.
*You **MUST** provide a **non-work e-mail** address where you will reliably receive messages.*

Personal Address: _____

City: _____ State: _____ Zip: _____ County: _____

Are you self-employed? ☐No ☐Yes If "Yes" complete the following:
Date Self-Employed Status Began: _____/ _____/ _____

Current Employer: _____ DD Provider #: _____
Agency Address (street number/city/state/zip): _____
_____ County _____
Agency Phone: _____ Agency Email:_____
Employment Start Date (month, day & year required): _____/_____/_____
Supervisor's Name: _____ _____ Phone: _____
(last) (first)
Supervisor's E-mail: _____
Date supervision began: (month, day & year required): _____/_____/_____
Work Location address (if different from agency mailing address):
_____
(street) (city) (state) (zip) (county)
Work Location Start Date (month, day & year required): _____/_____/_____

RN/DD WORK EXPERIENCE INFORMATION
(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)

Employer: _____ RN Experience: ☐ DD Experience: ☐
Agency Address (street number/city/state/zip): _____
_____ County _____
Agency Phone: _____ Agency Email:_____
Employment Start Date (month, day & year required): _____/_____/_____
Employment End Date (month, date and & year required): _____/_____/_____
Supervisor's Name: _____ _____ Phone: _____
(last) (first)

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Supervisor's E-mail: _____ _____
Title: _____
Role/Duties: _____
_____

ICF/DD ☐ **Self-Employed** ☐ **DODD Agency Provider** ☐

(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)

Employer: _____ **RN Experience:** ☐ **DD Experience:** ☐
Agency Address (street number/city/state/zip): _____
_____ **County** _____
Agency Phone: _____ **Agency Email:**_____
Employment Start Date (month, day & year required): _____/_____/_____
Employment End Date (month, date and & year required): _____/_____/_____
Supervisor's Name: _____ _____ **Phone:** _____
(last) **(first)**
Supervisor's E-mail: _____ _____
Title: _____
Role/Duties: _____
_____

ICF/DD ☐ **Self-Employed** ☐ **DODD Agency Provider** ☐

(Please complete for each DD and all RN employers and indicate if RN or DD experience or both.)

Employer: _____ **RN Experience:** ☐ **DD Experience:** ☐
Agency Address (street number/city/state/zip): _____
_____ **County** _____
Agency Phone: _____ **Agency Email:**_____
Employment Start Date (month, day & year required): _____/_____/_____
Employment End Date (month, date and & year required): _____/_____/_____
Supervisor Name: _____ _____ **Phone:** _____
(last) **(first)**
Supervisor's E-mail: _____
Title: _____
Role/Duties: _____
_____

ICF/DD ☐ **Self Employed** ☐ **DoDD Agency Provider** ☐

I attest that all information provided on this application is true, current, and correct.

_____ Date: _____
(Signature of RN Trainer Applicant)

Return completed registration (both pages) and $80 registration fee prior to class by mail, fax 216.861.0253) or e-mail to:
CCBDD 1275 Lakeside Avenue, Cleveland Ohio 44114 Attn: Patti Higgins, RN (higgins.patricia@cuyahogabdd.org)