FORM 1201-A Short
Six-Month Nurse Trainer Report to NH Bureau of Developmental Services Medication Committee
(For Programs Without Reportable Errors)

The purpose of this form is to maximize the safe use of medications and to increase awareness of medication errors through open communication, increased reporting and promotion of medication error prevention strategies.

REGION: _____ **Nurse Trainer Signature: _____**
Electronic signatures cannot be accepted at this time

1. Provider Agency Name:	3. Reporting Period Dates: _____to _____
2. Nurse Trainer Name:	

Service name:	**Cert type**	**# Ind**	**# Authorized providers**	**Hrs. per month**	**# Doses**	**# 1201 deficien-cies**	**Type of He-M 1201 deficiencies**	**# Frail Ind**	**# Psych meds**	**Psych Involvement**
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐
										Yes ☐ No ☐

Other Concerns: