| (Title and Address of Provider) | |
|---------------------------------|--|

Medication Administration Classroom Training for Direct Care Staff

| Training Date: | Training Time(s): | | | | |
|--|-------------------|--|--------------------------------------|------------------------------------|--|
| <u>Direct Care Staff</u> : By signing in and out on the <u>Medication Administration Training</u> as require <u>Disabilities on the date(s) stated on this sheet</u> | ed by the State | sheet, I am stating of Illinois Departm | that I attended a ent of Human Se | III 8 required clervices, Division | assroom hours of n of Developmental |
| Signatures of Direct Care Staff attending: | | | | | |
| Sign IN: | <u>Date</u> | Sign OUT: | | | <u>Date</u> |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| All Direct Care Staff who have signed in and instruction required by the State of Illinois De stated as the first step in authorization to adn provider named above. | partment of Hu | ıman Services, Div | ision of Develop | mental Disabil | ties on the date(3) |
| Nurse-Trainer Signature: | | | | Date: | pe same as training date(s) |

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