



Medication Technician Training Program Registration Form

Medication Technician Training Program – Initial and 2-year Clinical Certification

To be completed by supervisor or designated personnel:

Employee: _____ Work Site: _____

Position: _____ Department: _____

Supervisor: _____ Phone number: _____

Course Title: _____ **20 Hour Medication Class** _____ **2-year Clinical Update**

Course Date(s): _____

Course Time(s): _____

Course Location: _____ **Dimensional Health Care** _____

Email to: **lreese@chimes.org**
Human Resource Assistant
Please ensure "Medication Registration" is stated in the subject line of the email.

To be reviewed and signed by employee:

I understand that if I do not attend or call (410) 358-4279 to cancel attendance at the above specified course on the date(s) that I have registered, the cost of class will be deducted from my paycheck. The cost of the 20 Hour Medication class is \$165.00 and the cost of the 2 year Clinical Update is \$55.00. Failure to cancel will result in an automatic payroll deduction.

Employee Signature: _____ Date: _____

Original: Personnel File
Copy: Employee
Supervisor