

Ohio Department of Mental Retardation and Developmental Disabilities  
**Application to Register in the Train the Instructor Program**

|   |  |                  |
|---|--|------------------|
| Application Type:<br><input type="checkbox"/> For Initial Certification <input type="checkbox"/> Grandfathering | Application is for:<br><input type="checkbox"/> ODMR/DD Instructor <input type="checkbox"/> RN Trainer | Application Date |
|---|--|------------------|

|                    |                         |  |
|--------------------|-------------------------|--|
| RN/LPN License No. | License Expiration Date | RN Trainer Cert. Expiration Date (for ODMR/DD Instructor only) |
|--------------------|-------------------------|--|

|                                  |   |           |         |
|----------------------------------|---|-----------|---------|
| Applicant Name (Last, First, MI) | Mailing Address:<br><input type="checkbox"/> Home <input type="checkbox"/> Business | Phone No. | Fax No. |
|----------------------------------|---|-----------|---------|

|                |      |       |          |                |
|----------------|------|-------|----------|----------------|
| Street Address | City | State | Zip Code | E-Mail Address |
|----------------|------|-------|----------|----------------|

**Employers (attach additional sheet if necessary)**

|                 |   |   |
|-----------------|---|---|
| Employer Tax ID | Is Employer a Residential Facility ?<br><input type="checkbox"/> Yes ( If 'Yes', Facility Capacity: _____ ) | Is Employer's address Mailing Address ?<br><input type="checkbox"/> Yes |
|-----------------|---|---|

|               |           |         |
|---------------|-----------|---------|
| Employer Name | Phone No. | Fax No. |
|---------------|-----------|---------|

|                |      |       |          |                |
|----------------|------|-------|----------|----------------|
| Street Address | City | State | Zip Code | E-Mail Address |
|----------------|------|-------|----------|----------------|

|                 |   |   |
|-----------------|---|---|
| Employer Tax ID | Is Employer a Residential Facility ?<br><input type="checkbox"/> Yes ( If 'Yes', Facility Capacity: _____ ) | Is Employer's address Mailing Address ?<br><input type="checkbox"/> Yes |
|-----------------|---|---|

|               |           |         |
|---------------|-----------|---------|
| Employer Name | Phone No. | Fax No. |
|---------------|-----------|---------|

|                |      |       |          |                |
|----------------|------|-------|----------|----------------|
| Street Address | City | State | Zip Code | E-Mail Address |
|----------------|------|-------|----------|----------------|

**List Experience as a Nurse (attach additional sheet if necessary)**

| Period |     | Employer Name | Job Title |
|--------|-----|---------------|-----------|
| From:  | To: |               |           |
|        |     |               |           |
|        |     |               |           |
|        |     |               |           |
|        |     |               |           |
|        |     |               |           |

**List experience working with individuals with MR/DD (attach additional sheet if necessary)**

| Period |     | List experience working with individuals with MR/DD (attach additional sheet if necessary) |
|--------|-----|--|
| From:  | To: |  |
|        |     |  |
|        |     |  |
|        |     |  |
|        |     |  |

**Training Session(s) to Attend**

| Period |     | Instructor Name | Location/County | CE | * CertCat. M training ?      |
|--------|-----|-----------------|-----------------|----|------------------------------|
| From:  | To: |                 |                 |    | <input type="checkbox"/> Yes |
|        |     |                 |                 |    | <input type="checkbox"/> Yes |
|        |     |                 |                 |    | <input type="checkbox"/> Yes |

**Note: Certification Category IV: Medication admin., health-related activities, feeding tube by Nursing Delegation for individuals of a residential facility with 17+ beds who are on a field trip.**