STATE OF MARYLAND

MARYLAND BOARD OF NURSING
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MEDICATION TECHNICIAN TRAINING PROGRAM
REGISTERED NURSE FACULTY
VERIFICATION OF TRAINING COURSE COMPLETION

Pursuant to Code of Maryland Regulations (COMAR) 10.39.04.06C, the faculty for a Medication Technician Training Program (MTTP) shall consist of a registered nurse (RN) who:

(1) Is licensed to practice in the State of Maryland; and

(2) Has completed a course of instruction approved by the Board designed to instruct the RN on how to teach the MTTP for the specific practice setting in which the enrolled students are to work.

PART I: ***Licensee Information***

Full Name: ____ **License No(s).:** _____________________

Business Address: This address is your public address of record and, pursuant to the Maryland Public Information Act, will be made available to the public on the Board's public website in order to identify you as a qualified instructor for the MTTP.

____
Street/Apartment No./P.O. Box

____
City County State Zip Code

Home Address: This address will be used for Board mailings only. However, please be advised that if you do not provide a business address, your home address becomes your public address of record and, pursuant to the Maryland Public Information Act, will be made available to the public on the Board's public website in order to identify you as a qualified instructor for the MTTP.

____
Street/Apartment No.

____
City County State Zip Code

E-mail address: _____________________________ **Phone Number:** ____________________________

The Board is not authorized under the Maryland Public Information Act to disclose your e-mail address or personal phone number to the public. However, in order to provide the public with additional contact information for those who are qualified to serve as instructors for the MTTP, you may authorize the Board to post this information on its public website. Please check one of the following:

☐ I **DO** authorize the Maryland Board of Nursing to post my e-mail address and personal phone number on its public website for the purpose of identifying me as a qualified instructor for the MTTP.

☐ I **DO NOT** authorize the Maryland Board of Nursing to post my e-mail address and personal phone number on its public website for the purpose of identifying me as a qualified instructor for the MTTP.

Signature of Licensee: ______________________________________ **Date:** ______________________________

PART II: *Training Verification*

Program Information

Name of Agency/Institution/Entity Providing Board-Approved MTTP RN Faculty Training Course:

____

Business Address:

____
Street/Apartment No./P.O. Box

____
City County State Zip Code

Training Verification

Name of Instructor: ____

Name of RN Trainee: ____

Attestation:

I hereby attest, under the penalties of perjury, that on or about ______________________________ ______, 20
[*Month*] [*Day*]

_______, ____, RN, License No. _____________________,
[*Year*] [*Name of Licensee*] [*RN License No.*]

completed the Board-approved MTTP RN Faculty Training Course for the following practice area(s):

☐ Supervised group living settings ☐ Supervised or sheltered work settings

☐ Independent living settings ☐ Schools

☐ Correctional institutions ☐ Hospice care

☐ Adult medical day care centers ☐ Child care centers established for children with health or medical conditions or both

Signature of Instructor: _____________________________________ **Date:** ______________________________