

YOUTH CAMP MEDICATION ADMINISTRATION CERTIFICATE HOLDER APPLICATION

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-463-3464 ext.78417

I. APPLICANT		
CAMP APPLICANT NAME	CAMP NAME	CAMP LICENSE NUMBER
APPLICANT'S MAILING ADDRESS		APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE
APPLICANT'S EMAIL		APPLICANT'S CELL PHONE
II. AGE		
ARE YOU AN ADULT, AS DEFINED IN COMAR 10.16.06 AND 10.16.07?		<input type="checkbox"/> YES <input type="checkbox"/> NO
III. TRAINING COURSE		
A) HAVE YOU SUCCESSFULLY COMPLETED A MEDICATION ADMINISTRATION COURSE APPROVED BY THE DEPARTMENT?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
B) NAME OF APPROVED COURSE		
C) HAVE YOU ATTACHED A COPY OF YOUR COMPLETION CERTIFICATE?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
V. APPLICANT'S SIGNATURE		
<p>I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-MDH ext. 78417.</i></p>		
X _____ APPLICANT'S SIGNATURE	_____ DATE	
FOR INTERNAL USE ONLY (Do Not Write Below This Line)		
TRACKING #: _____		
<input type="checkbox"/> APPROVED		
<input type="checkbox"/> DENIED Reason: _____		
X _____ CHHCS CHIEF'S SIGNATURE	_____ DATE	