YOUTH CAMP MEDICATION ADMINISTRATION COURSE 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 1-877-4MD-MDH ext. 8417

I. APPLICANT INFORMATION

APPLICANT'S NAME

APPLICANT'S MAILING ADDRESS	APPLICANT'S WORK PHONE
CITY STATE ZIP CODE	APPLICANT'S CELL PHONE

APPLICANT'S EMAIL

II. BUSINESS INFORMATION

BUSINESS NAME

BUSINESS MAILING ADDRESS	CITY	STATE	ZIP CODE

NAME OF TRAINING

III. INSTRUCTOR CREDENTIALS *(FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMAITON ON ANOTHER SHEET OF PAPER)*

INSTRUCTOR'S NAME

WHICH LICENSE TYPE DO YOU HOLD?

☐ PHYSICIAN   ☐ REGISTERED NURSE   ☐ CERTIFIED NURSE PRACTITIONER

LICENSE NUMBER:

IV. WRITTEN MATERIALS

SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:

A) Training manual
B) All handouts
B) All presentations
C) All exams
D) Certificate issued to student upon completion

V. APPLICANT'S SIGNATURE

I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding routine medication, except for insulin, at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. *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.*

✗ _____   **DATE** _____
APPLICANT'S SIGNATURE

FOR INTERNAL USE ONLY *(Do Not Write Below This Line)*

☐ APPROVED   ☐ DENIED   Reason:_____   TRACKING #:_____

✗ _____   **DATE** _____
EHB DIRECTOR'S SIGNATURE