_____
(Title and Address of Provider)

Medication Administration Classroom Training for Direct Care Staff

Training Date: _____ Training Time(s): _____ _____ _____ _____

Direct Care Staff: By signing in and out on this attendance sheet, I am stating that I attended all 8 required classroom hours of Medication Administration Training as required by the State of Illinois Department of Human Services, Division of Developmental Disabilities on the date(s) stated on this sheet.

Signatures of Direct Care Staff attending:

Sign IN:	Date	Sign OUT:	Date

SAMPLE

All Direct Care Staff who have signed in and out on this attendance form have completed the full required 8 hours of classroom instruction required by the State of Illinois Department of Human Services, Division of Developmental Disabilities on the date(3) stated as the first step in authorization to administer medications as defined by Administrative Rule 116, individuals served by the provider named above.

Nurse-Trainer Signature: _____ Date: _____
[must be same as training date(s)]