BLANCHARD VALLEY CENTER/HCBDD

Continuing Education Registration for Certification I, II, and III

ALL INFORMATION MUST BE COMPLETED FOR THIS REGISTRATION TO BE PROCESSED

Date of Registration: _____

Name: _____ Date of Birth: _____

Address: _____ Soc. Sec. #: _____

City/State: _____

Phone # _____

I am registering for Continuing Education for:

☐ Certification 1: Medication Admin Expiration Date _____

☐ Certification 2: Tube Feeding Expiration Date _____

☐ Certification 3: Insulin Injection Expiration Date _____

Expiration date of your current Certification 1 certificate: _____

Have you taken Continuing Education through BVC/HCBDD? ☐ YES ☐ NO

Are you a DODD certified Independent Provider : ☐ YES ☐ NO

Current DD Employer:

_____

Employer Address:

_____

Work phone: _____ Home Phone: _____

Immediate Supervisor (Please Print): _____

Please check all areas that apply to your DD employment

☐ Family Supports ☐ Facilities with 5 or fewer beds

☐ Supported Living ☐ Facilities with 6 – 16 beds

☐ Certified home and Community Based Provider ☐ Other _____

Directions for returning completed registration **by mail or fax:** **Mail to:**	Directions for returning completed registration **in person:** **Bring to:**
Michelle Darrach, RN, Training Coordinator Blanchard Valley Center/HCBDD 1701 East Main Cross Findlay Ohio 45840 Phone: (419) 422-6387 ext 1219 Fax: (419) 425-7053	Dawn Webb Blanchard Valley Center/SSA Dept. 1700 East Sandusky Street Findlay, Ohio 45840 Phone: (419) 425-8747 Fax: (419) 425-8748