**INFORMATION FOR EMPLOYERS AND STUDENTS**

* QMAP students must provide proof of age. **Minimum age is 18**. Valid pictured ID is required.
* Students should not work the overnight shift before attending the QMAP class and should not work overnight before testing.
* Students must read, write, and speak English.
* Students should have basic math skills.
* Employers must conduct a criminal background check prior to allowing medication administration by the QMAP employee.
* I have been informed of this information prior to class.
* Fees:

**$125.00 for the 2-day class & test \_\_\_\_\_\_**

**Fee due at time of enrollment (cash, check or money order payable to WCAHEC).**

* **The fee is non-refundable without ‘5 business day’ notice to cancel or reschedule.**

Student Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Class Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**email to lapplegate@wcahec.org** or hand deliver with payment to

**Linda Applegate at Western Colorado Area Health Education Center**

**2938 North Ave. #B, Grand Junction, CO. 81504**

**\*\*\* ATTENDEES ARE REQUIRED TO BRING THEIR PRINTED SYLLABUS/ADVANCED STUDY GUIDE TO CLASS WITH THEM - THERE IS A $2.00 FEE FOR A REPLACEMENT \*\*\***

**Qualified Medication Administration Personnel (QMAP) Mandatory Disclosure Form**

In accordance with:

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT (CDPHE)

Health Facilities and Emergency Medical Services Division (HFEMSD)

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 24 - MEDICATION ADMINISTRATION REGULATIONS, 6 CCR 1011-1 Chapter 24

**Student Name (please print):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photo ID type/#/expiration date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing, I am acknowledging and making the following declarations:**

1. I declare that I am at least 18 years of age.

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I declare that I have never had a professional license to practice nursing, medicine, or pharmacy revoked in this or any other state for reasons directly related to the administration of medications.
2. I understand to attend/pass this class that I must have at least a basic and working knowledge of math and the English language, both written and verbal.
3. I acknowledge that the operator or administrator of each facility that hires a QMAP must provide on the job training ensuring your proficiency for medication administration before beginning to administer medications.

**Student Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_