

## RETRAINING VERIFICATION FORM - AMAP

The purpose of this form is for the facility to verify and document the mandatory two (2) year retraining of an AMAP who was trained at another facility. This document is to be kept in the employee's file and presented to the OHFLAC representative, upon request.

AMAP staff cannot administer medication until retraining is completed by an authorized AMAP RN.

### RETRAINING INFORMATION - AMAP

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

SITE OF INITIAL TRAINING: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

DATE PASSED STATE TEST: \_\_\_\_\_

### RETRAINING VERIFICATION

Documentation of the method used to retraining must be attached to this form (e.g., the medication pass checklist, testing, etc.).

DATE OF THE TRAINING: \_\_\_\_\_

FACILITY / PROGRAM NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

AMAP RN NAME: \_\_\_\_\_

*(PLEASE PRINT)*

AMAP RN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Statement:** By signing this form, I verify that the unlicensed medication personnel listed above has demonstrated competency to administer medication for this facility.