

Roster of Non-Licensed Personnel Who Have Successfully Completed the Texas Approved Training Program in Medication Administration

Please type and/or generate by computer. Use separate roster reports for the basic course and the continuing education course.

TO: Texas Department of Aging and Disability Services
Medication Aide Program
Mail Code: E-416
P.O. Box 149030
Austin, Texas 78714-9030

From: _____
Name of Approved Training Institution

_____ TX _____
City State ZIP Code

- Basic 140 Hours Training Course
 Continuing Education Training Course

Date Training Completed: _____

1.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
2.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
3.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
4.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
5.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
6.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
7.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code
8.	Last Name	First Name	MI	Social Security No.	Name Change	Permit No.
Address				City		ZIP Code

Signature — RN Instructor

Program Hours Taught (RN)

Signature — RPH Instructor

Program Hours Taught (RPH)

Signature — Training Institution Dean/Director

Date (mm/dd/yyyy)