Connecticut Department of Children and Families

MEDICATION ADMINISTRATION PROGRAM INTERNSHIP VERIFICATION FORM

DCF-2273
4/18 (Rev)

Employee's Last Name:		Employee's First Name:
Employing Facility:		
Facility Phone Number:	Facility Nurse's Phone Number:	Facility Nurse's E-mail

The above candidate has successfully completed all components of the Medication Certification Internship at this DCF licensed/operated facility. This internship has included the following:

- Orientation to facility policy and procedure for medication administration
- Shadowing of an experienced medication certified staff in good standing or facility nurse during actual medication passes. **Minimum of 2 complete medication passes.**
- Supervised medication passes under the direct supervision of nurse or experienced medication certified staff in good standing utilizing the DCF Medication Administration Procedure. **Minimum of 2 complete medication passes.**

A certificate will be issued by the Department of Children and Families upon receipt of this signed and dated form.

EMPLOYEE MAY NOT ADMINISTER MEDICATION UNTIL EMPLOYING FACILITY HAS RECEIVED CERTIFICATE.

Once this form is completed and signed, please submit to DCF Medication Administration Program:

Email: Med.admin@ct.gov

Fax: 860-550-6541

Mailing Address: DCF Medication Administration Program
Health and Wellness Division
505 Hudson Street
Hartford, CT 06106

Employee's Signature		Date:
Facility Nurse's Name	Facility Nurse's Signature	Date:
Facility Director's Name:	Facility Director's Signature	Date: