ISDH QMA Insulin Administration Facility and MED ED, INC. Agreement

Student's Name:_____ Class Start Date:_____

_____

(Facility Name and location including address)

is an approved site for conducting the ISDH QMA Insulin Administration competencies listed below; **under the direct supervision of a designated registered nurse at the student's facility- the student must perform these with 100% accuracy.**

___ ISDH Insulin Adm. Competency Checklist Form-Preparing an Insulin Pen & Administering Insulin By Subcutaneous Injection- 100% Accuracy Required

____ ISDH Insulin Adm. Competency Checklist Form-Withdrawing Insulin from a Vial and Administering Insulin by Subcutaneous Injection- 100% Accuracy Required

Under the direction of ISDH, please provide to MED ED the designated contact name, email address and phone number for the student's facility.

Contact Name:_____ Email _____ Phone No. _____

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I ACCEPT AND AGREE TO CONTACT MED ED IF THE STUDENT IS NOT ABLE TO COMPLETE THE COMPETENCIES TRAINING AT THIS FACILITY. PLEASE NOTIFY US ASAP PAT@USMEDED.COM

_____ _____

Facility D.O.N. or Administrator Signature Date

_____

Print Name and Title (D.O.N. or Administrator)

_____

MED ED, INC. Representative Signature Date

PAT CHRISTOFF, R.N.
CNA/QMA Program Director

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