KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

CERTIFIED MEDICATION AIDE CONTINUING EDUCATION
Instructor Roster

This information must be typed and completed by the instructor. Submit instructor roster, renewal application forms completed by each of the candidates, **$20.00 non-refundable fee for each applicant**, and any attachments to the Kansas Department of Health and Environment after the candidates have successfully completed the course.

Instructor Name:_____

Instructor Number: _____ Course Number:_____ Course Begins:___/____/____ Ends:____/____/

Sponsoring School Name:_____

Address:_____

The students on this roster satisfactorily completed the specified hours of the Kansas Certified Medication Aide Continuing Education course in accordance with KAR 28-39-169c.

_____ ____/_____/_____
Authorized Signature Date

INSTRUCTOR USE ONLY NAME (Last, First, MI, Other)	**KDADS USE ONLY**

RETURN TO: HEALTH OCCUPATIONS CREDENTIALING
612 S Kansas Ave
Topeka, KS 66603

Website: www.kdads.ks.gov/hoc