EXPERIENCE DOCUMENTATION REPORT FORM
TEXAS HEALTH & HUMAN SERVICES COMMISSION
MEDICATION AIDE PROGRAM - MAIL CODE E416
P. O. BOX 149030
AUSTIN, TX 78714-9030

APPLICANT_____SOCIAL SECURITY #_____

TRAINING SCHOOL_____
****

Form must be filled out in its entirety by the individual certifying that the information submitted is correct.

I,_____, certify that I have employed
(FACILITY ADMINISTRATOR/PROGRAM DIRECTOR/DON)

_____from_____to_____ and that I know
(Applicant)
of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide; or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

1. Place of Employment_____

2. Address_____
Street No. City State Zip

3. Phone Number including Area Code_____

4. Type of Facility_____

5. Job Title of Applicant_____

6. Nurse Aide Certificate Number (if applicable)_____
Expiration date_____

7. Type of work performed (be specific)_____

On this _____day of_____,20___, in_____,_____
I certify under penalty of perjury that the information submitted is true and correct.

_____
SIGNATURE OF ADMINISTRATOR/PROGRAM DIRECTOR/DON
Facility Vendor Number_____

Before me, a Notary Public in_____County, Texas on this day personally appeared_____, known to me to be the
(ADMINISTRATOR/PROGRAM DIRECTOR/DON)
person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____day of _____,20___.

_____
(Signature of Notary)

Photocopy if additional copies are needed 9/1/17