

EMPLOYEE VERIFICATION FORM

Revised 10.07.11

The caregiver asks his/her agency employer complete this form & then he/she faxes it along with a copy of his/her training certificate to HCDDS Intake Dept. at 559-6602 or mail it to HCDDS Intake Dept., 1520 Madison Road / Cincinnati 45206.

_____, who works for _____
meets the following requirements:

- _____ Not on Abuser Registry
- _____ Not on Nurse's Aide Registry
- _____ Completed Criminal Background Check (BCII)
- _____ Current First Aid and CPR certification
- _____ Permitted to drive per agency standards
- _____ Is an employee in Good Standing
- _____ Has completed MUI, Rights, Universal Precautions, An Overview of Serving Individuals with DD and An Overview of the Medicaid System training

VERIFICATION SIGNATURE COMPLETED BY AGENCY

Signature: _____
Name: _____
Title: _____
Agency: _____

INFORMATION TO POST ON WEBSITE

Caregiver phone number: _____
Caregiver email address: _____

COMPLETE BELOW OR SEND TRAINING CERTIFICATE

_____ has completed required training from the Kelly O' Leary Center.

Signature: _____
Name: _____
Title: _____