

## REGISTRATION FORM FOR TRAINING

Please complete one of these forms per each training for which you are registering. Email the completed form to the Training Program of Developmental Disability Services of Jackson County (see email address below). **The Registration Form must be received at least five (5) days before the training begins.** (Copy or print additional forms as needed, add additional lines as needed.)

**Please Print:**

Training Course Title:	
Location of Training:	
Date & Time:	
Your Facility/Agency:	
Address/City/Zip:	
Contact Person:	
Telephone No.:	
Email Address:	

**Please Note:**

- (1) If registering for a Level 1 Medication training class, you must include the **Social Security number** and the **Date of Birth** for each registrant.
- (2) If registering for a Medication Update training class, a copy of the registrant's **original** Level 1 Medication Aide certificate **MUST** accompany this form.

	Name of Registrant	Job Title	S. S. Number	DOB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Please list any accommodations needed for training participants: \_\_\_\_\_

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Contact: Rita Trotter, Training Coordinator at [ritat@eitas.org](mailto:ritat@eitas.org) or call at (816) 822-8900 for any questions.