## **Developmental Disabilities Division**



## **Medication Assistance Trainer Agreement**

Your status as a certified Medication Assistance Trainer is a privilege extended to you by the Wyoming Department of Health, Developmental Disabilities Division (DDD). The continuation of this privilege is dependent upon several factors including an understanding of, and adherence to the following agreement:

- 1. I understand that I am not an employee of the DDD and that I will not be compensated by the State of Wyoming for any services rendered in my capacity as a trainer.
- 2. I understand that I am **not** covered under any liability protection by the State of Wyoming.
- 3. I understand that I am required to inform the DDD Training Coordinator of any changes to my email address so that I may be kept informed of changes to the Medication Assistance Training program.
- 4. I understand that I must utilize the entire DDD Medication Assistance Training (MAT) curriculum, including the manual, quizzes and final exam, roster, and survey as the basis of my training, and I may add to the curriculum, as need dictates.
- 5. I understand that I can only teach the MAT curriculum and issue MAT certificates while I am in good standing with the DDD.
- 6. I understand that DDD Nursing staff will make unannounced visits to the trainings that I conduct, and to help facilitate the scheduling of these visits, I will notify the DDD via online registration on the Division's website at least two (2) weeks in advance of any training that is scheduled.
- 7. I understand that I am expected to conduct trainings in an environment that is conducive to a meaningful learning experience.
- 8. I understand that I am required to present a copy of the MAT manual to my students with the understanding that this manual will become the property of the student.
- 9. I understand that upon a student's successful completion of this class, I am required to promptly issue them the standard paper certificate for their keeping.
- 10. I understand that within three (3) business days after the completion of a training I will forward to the DDD Training Coordinator by mail or fax the following materials:
  - o DDD student roster that is legible and completely filled out
  - o DDD surveys generated by each student after the training
  - o DDD original final exams for each student
- 11. I understand that my tenure as a Medication Assistant Trainer is dependent of my continued adherence to the items mentioned in this agreement, as well as, my ability to demonstrate competency during the Medication Assistance Trainer re-certification process.
- 12. I understand that the DDD has the right to sanction or revoke my Medication Assistance Trainer certification should I be in violation of this agreement.

By the application of my signature, I acan and agree to all of the above statement.		cand,
Trainer Printed Name & Signature	Date	Developmental Disabilities Division 6101 Yellowstone Road, Suite 1860 Cheyenne, WY 82002
Developmental Disabilities Division	Implemented April 27, 2011	www.health.wvo.gov/ddd

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