

MEDICATION ADMINISTRATION TRAINING PROGRAM – PROVIDER ROLE DESIGNATION/VERIFICATION FORM

Please complete the information on this page to identify your Provider. Please complete the information on the following page(s) to identify your Provider Administrator and the Medication Administration Program's Primary Contact and to verify employment of re-certifying or new trainers. You may also use this form to indicate staff who are no longer provider administrators or primary contacts or trainers who have left the provider and that we should remove from your provider in the online system.

The completed form can be scanned and attached to an existing help desk ticket. or a new help desk ticket can be created at www.mahelpdesk.com. If you have an existing ticket, please include your ticket number [here](#): [REDACTED]

Please note: Only providers that fall into the below Program types and Chapters are eligible to participate in the Medication Administration Training Program.

Program Type: *Aging, Assisted Living, OCYF, ODP, PCH, *OMHSAS-Waiver Approved Providers (CRR, LTSR, Crisis Intervention, RTF-A)*

Program Chapter: *Chapter 11, 2800, 3800, 2380, 2390, 6400, 6600, 2600*

Please indicate the purpose of this form (check all that apply):

- ☐ This is a new provider to be added to the system. ■ New Trainer registration for new provider ☐ Yes ☐ No
- ☐ This provider is replacing a previous provider. Name of provider to be removed:
- ☐ Add or Change Provider Administrator ■ Administrator name removed: from role: from provider:
- ☐ Add or Change Primary Contact ■ Primary Contact name removed: from role: from provider:
- ☐ Remove Provider Administrator or Primary Contact
- ☐ Trainer changing roles or leaving provider
- ☐ Add New re-certifying Trainer ■ re-certifying Trainer employed at provider ☐ Yes ☐ No

Description	
Provider Name	
County	
Street Address	
City/ State/ Zip	
Program Type & Chapter	
License/ FEIN/NPI/MPI Number	

The Provider Administrators and Primary contacts have a role in reviewing trainers assigned to their providers, paying for trainers, etc. Please keep these roles current. – Complete page 2

Revised: October 13, 2026

Please note: Provider Administrators and Primary Contacts of the verified provider must have an account in the Medication Administration Training Program (medadmin.myodp.org). If you are unsure if you have an account in the system, please submit a ticket through www.mahelpdesk.com.

Please print legibly so that your information is entered into the system accurately.

Role Information	Provider Administrator
First Name and Last Name	
Chapter	
Email Address	
Primary Phone #	
Secondary Phone #	

Role Information	Second Provider Administrator (Optional)
First Name and Last Name	
Chapter	
Email Address	
Primary Phone #	
Secondary Phone #	

Please note: Provider Administrators and Primary Contacts of the verified provider must have an account in the Medication Administration Training Program (medadmin.myodp.org). If you are unsure if you have an account in the system, please submit a ticket through www.mahelpdesk.com.

Please print legibly so that your information is entered into the system accurately.

Role Information	Medication Administration Program Primary Contact
First Name and Last Name	
Chapter	
Email Address	
Primary Phone #	
Secondary Phone #	

Role Information	Second Medication Administration Program Primary Contact (Optional)
First Name and Last Name	
Chapter	
Email Address	
Primary Phone #	
Secondary Phone #	

Names of Provider Administrators, Primary Contacts, and Trainers to be Removed from Provider

Name (First and Last)	Email Address	Remove role only	Remove role and provider	Replacement Name
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Names of the Trainers being certified/re-certified or added to the Provider

Name (First and Last)	Email Address	New or Re-certifying Trainer	Date of hire or contract date for existing providers
		Choose from dropdown	
		Choose from dropdown	
		Choose from dropdown	
		Choose from dropdown	
		Choose from dropdown	

☐ I, the Provider Administrator, attest that the trainer candidate is employed by my provider or has a provider-to-provider contract in place and that I have reviewed my provider's Medication Administration Policies and Procedures with the trainer candidate and they meet the train-the-trainer course pre-requisites.

Provider Administrator Name

Provider Administrator E-mail Address

Provider Administrator Phone Number

Provider Administrator Signature

Date