Medication Administration Training (MAT) Trainer Application

Please complete the information requested below:

First Name:	**Middle Initial**:	**Last Name:**
Profession: (check one) ☐ RN ☐ Physician Assistant ☐ LPN ☐ Nurse Practitioner ☐ Physician ☐ Pharmacist You must have a current, valid **VIRGINIA** license	Date of Birth:	Professional License #: Professional License Expiration Date:

Home Address

Street:

City: State: Zip Code:

Telephone number (including area code)

Email:

Occupation / Job Title

Organization (Employer or Trading Name)

Work Address

Street:

City: State: Zip Code:

Telephone number (including area code)

Email:

Training Experience

List all of your training experiences with adult learners:

- include the course title & overview of content,
- client type
- number of participants

(If you have no formal teaching or training qualifications, please explain why you believe you are able to deliver MAT training.)

Recommendations:

Include **three signed** letters of recommendation with your application. Recommendations should be from:

- someone who knows you and your work; and/or
- someone who has seen you train others; and/or
- someone who has supervised you.

There is no required format for submission of letters of recommendation. However, the letters should be **signed** and include comments concerning

- your professionalism;
- your knowledge of health care; and,
- ability to successfully train others.

Please confirm the following:

☐ I have a current valid Virginia license as an RN, LPN, physician, nurse practitioner, physician assistant or pharmacist.

☐ I have enclosed **three signed** letters of recommendation.

☐ I have enclosed a copy of my current resume or curriculum vitae (CV).

☐ I confirm the information I have provided with this application is accurate and a true sample of my training activities.

☐ I understand that if selected, I must attend and successfully complete a **two-day** Training of Trainer (MAT TOT) course facilitated by an approved MASTER Trainer to become certified as a MAT Trainer. **(Do not send course fees unless approved to attend.)**

My preferred training location is:

☐ Central ☐ Northern

☐ Tidewater ☐ Southwest

As an *approved* MAT Trainer,

☐ I understand that I must comply with all MAT Program guidelines and changes. I must shadow a MAT class before I start facilitating classes as an approved MAT Trainer. Also, I must facilitate at least **three** MAT classes during my three-year term.

☐ I understand that I must assemble a MAT Trainer Kit per the requirements of the MAT program. (The estimated cost to assemble a complete kit is $400–$600.)

☐ I understand that as an approved MAT Trainer I must maintain current contact information with Medical Home Plus, including mailing address, phone number and a working email address.

Signature: _____

Date: _____ **Unsigned applications will not be accepted.**