Department of Mental Health

Division of Developmental Disabilities

Request to Challenge

DMH DD Level 1 Medication Aide Examination

Name:

Address:

Email Address:       Telephone:

Date of Birth:       Social Security Number:

I request consideration to challenge the written and practicum test without completion of the course because (check appropriate response)

[ ]  I have successfully completed a pharmacology course

 Institution:

 Date of completion:

 Please attach a copy of transcript.

[ ]  I have successfully completed a medication administration course of at least 16 hours

 Instructor:

 Date of completion:

 Agency sponsoring course:

 Please attach a copy of your certificate.

 Please attach evidence of the curriculum content.

 [ ]  Other

 Please Explain

Signature:

Submit this request to Medaide@dmh.mo.gov

(For Office Use Only) Your Request to Challenge has been:

 [ ]  Approved. Please present this approval to an approved instructor for testing.

 [ ]  Denied.

 Reasons/Comments:

If you have questions or concerns please contact:

Email Medaide@dmh.mo.gov