TEXAS Health and Human Services

Form 5523
November 2020-E

Medication Aide Program

Medication Aide Experience Documentation Report

1. Applicant Name (last, first, middle initial)			2. Social Security No.
3. Applicant Job Title			
4. Place of Employment			
5. Address (Street or P.O. Box)	6. City	7. State	8. ZIP Code
9. Phone Number (Including Area Code)			
10. Type of Facility	11. Applicant Job Title	12. Nurse Aide Certification No. (if Applicable)	13. Type of Work Performed
14. Facility Administrator/Program Director/DON			

I, _____ (Facility Administrator/Program Director/DON), certify that I have employed _____ (Applicant) from _____ to _____

and that I know of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide, or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

On this _____ day of _____, 20 _____, in _____

I certify under penalty of perjury that the information submitted is true and correct.

_____ Signature — Facility Administrator/Program Director/DON

_____ Facility Vendor No.

The State of _____

County of _____

Before me, a notary public in _____ County, Texas on this day personally appeared

_____
(Facility Administrator/Program Director/DON)
whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand seal of office, this _____ day of _____, 20 _____

_____
Signature — Notary

Place Notary Seal or Stamp Here

_____
Printed Name — Notary

_____
Commission Expiration Date