



Certified Medication Technician Letter of Recommendation

SECTION A

To be completed by the Administrator or Director of Nursing at the LTC Facility:

CMT APPLICANT'S NAME: (PRINT) _____

Please check on of the following below box:

Currently employed

I certify the individual named above is currently employed and in good standing at the facility listed below where they have a minimum of 6 months experience working as a Certified Nurse Assistant.

I hereby agree to provide a minimum of 8 hours of clinical observation under the supervision of a Registered Nurse for the above-named applicant to facilitate completion of the CMT Program at St. Charles Community College.

Currently unemployed

I certify the individual named above was previously employed at the facility listed below where they completed a minimum of 6 months experience working as a Certified Nurse Assistant.

DON/ADMINISTRATOR'S NAME: (PRINT) _____

DON/ADMINISTRATOR'S SIGNATURE: _____ DATE: _____

NAME OF LTC FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____

WORK E-MAIL: _____

Please submit form to:

Student must submit document to thier Canvas CMT New Student Preparation Course. Once tuition is paid, student will recived how to access their Canvas CMT New Student Preparation Course.