# Certified Medication Technician Letter of Recommendation

The information below should be completed by the CMT applicant's Director of Nursing or Administrator at the applicant's place of employment.

CMT APPLICANT'S NAME: (PRINT)_____

I hereby verify that the above named applicant meets the SCC CMT admission requirement of a minimum of 6 months experience as a Certified Nurse Assistant and I recommend that the applicant be accepted into the Certified Medication Technician program at St. Charles Community College.

I hereby agree to provide a minimum of 24 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. I understand that SCC is required to enter into a clinical site agreement with the facility and will complete the site agreement as provided by the applicant. *(Failure to execute a clinical site agreement will result in the applicant being denied participation in the clinical requirement and subsequent course failure)*

APPLICANT'S DATES OF EMPLOYMENT_____ TO_____

DON/ADMINISTRATOR'S NAME: (PRINT)_____

DON/ADMINISTRATOR'S SIGNATURE:_____DATE:_____

EMPLOYING INSTUTION:_____

WORK ADDRESS:_____

CITY:_____STATE: _____ ZIP: _____

WORK PHONE: _____

WORK E-MAIL:_____