|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **JOB DESCRIPTION - Addendum** | | | | | |
| **JOB TITLE** | CERTIFIED MEDICATION TECHNICIAN | | | **pAYROLL JOB CODE** | 100 – DIRECT CARE |
| **LOCATION** | FIELD | | | **credentials** | CMT |
| **Department** | DIRECT CARE | | | **REPORTS TO** | RN |
| **fsla sTATUS** | NONEXEMPT | **STARTING PTO LEVEL** | MD | **EMPLOYMENT CLASS** | FT, PT, or PRN |

**Summary**

This addendum applies to individuals who possess a medication technician certification (CMT) and is in addition to the standard Caregiver or Certified Nursing Assistant (CNA) job description. ***This is not a stand-alone job description and may only be used along with one of these.***

**Essential Job Duties AND Responsibilities**

|  |
| --- |
| Assists clients with administration of medications as ordered by a physician and instructed by the registered nurse. |
| Adheres to all instructions as ordered and immediately reports any new medications or dose changes to agency staff. |
| Completes medication administration records accurately and completely per agency policy and registered nurse instruction. |
| Maintains certification and immediately reports any changes in certification to agency staff. |

**REGULATORY REQUIREMENTS:**

* Certification and experience:
* Certified Medication Technician certificate obtained by:
* Completion of an approved course.
* Certified by the applicable State Department of licensing.
* On-the-job instruction relative to specific patient needs and continuing in-service training, so that patient safety may be assured and the medication administration needs of the patient are met.

|  |  |  |
| --- | --- | --- |
| **Acknowledgement** | | |
| I have read the above job description addendum and fully understand the requirements set forth. I understand the agency reserves the right to revise and/or changes job duties, tasks, work hours/shifts, and work requirements at any time. I have noted below any job duties that I am not able to perform, with or without accommodation. I have also noted any accommodations that are required to enable me to perform these duties.  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Employee Print Name: | Employee Signature: | Date: |
| Supervisor Print Name: | Supervisor Signature: | Date: |