DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

Limited Lay Administration of Medications (LLAM)
Participant Prerequisite Checklist

Participants in the Limited Lay Administration of Medication (LLAM) program must meet the following criteria before attending the required (check one) ___15-hour Limited Lay Administration of Medication (LLAM) course for new participants / ___6-hour Limited Lay Administration of Medication (LLAM) recertification course for renewing participants. This completed checklist must be signed by the agency administrator and MUST accompany participant to class for review by LLAM instructor. Appropriate section below to be completed by agency. If participant is RENEWING, original/copy of most recent letter of completion MUST accompany them to renewal class for verification. Participant and agency staff signatures on this form indicate that the information contained on this form is true and correct to the best of their knowledge. **Agencies MUST keep a copy of this completed form in the employee’s file.**

**Participant Name:**  ____________________________  **Class Date(s):**  ____________________________

**CDS Logon ID #:**  ____________________________  **CPR Pending: Class date (New Staff ONLY):**  ____________________________

**New Participant**
1. Participant is 18 years old or older  **Yes ☐  No ☐**  **DOB:**  ____________________________

2. Participant is current in CPR certification.  **Yes ☐  No ☐**  **Date of expiration on CPR Card:**  ____________________________

3. Participant can read, write and speak English (as validated by agency policy)  **Yes ☐  No ☐

4. Participant has demonstrated competency in basic math (addition, subtraction, metric, and apothecary). Validated by administration of math exam with score of 80% or better by participating agency.  **Date of Exam & Score:**  ____________________________

**Agency:**  ____________________________________________  **Date:**  ____________________________

**Participants Signature:**  ____________________________________________  **Date:**  ____________________________

**Agency Administrator/Designee:**  ____________________________________________

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**Renewing Participant**
1. Date of last LLAM class:  ____________________________

2. Participant is current in CPR certification.  **Yes ☐  No ☐**  **Date of expiration on CPR card:**  ____________________________

3. As of (date) ___________, the participant meets all criteria to take the LLAM recertification class.  **Agency:**  ____________________________________________  **Date:**  ____________________________

**Participants Signature:**  ____________________________________________  **Date:**  ____________________________

**Agency Administrator/Designee:**  ____________________________________________

**Note:**  Please bring a copy of the LLAM course manual, pen/pencil, and Photo I.D. to class. LLAM manuals are to be provided by employing agency.