Exhibit B

Division of Developmental Disabilities Services
Community Services

Self Administration of Medication Approval Form-Shared Living

This verifies that _____ successfully completed the DDDS Self Administration of Medication Assessment-Shared Living and/or the Self-Administration of Medication-Shared Living Training Program on_____.

The undersigned are in agreement that _____ continues to exhibit the interest, ability, and skills necessary to self-medicate.

Service Recipient:	Date:
Registered Nurse:	Date:
Support Coordinator:	Date:
Shared Living Provider:	Date:
Behavior Analyst (if applicable):	Date:
Guardian (if applicable):	Date:

9.13.24