**NOTIFICATION OF MEDICATION ATTENDANT CERTIFIED**

**EMPLOYMENT & TERMINATION**

 ***Falsified documents submitted to this office will be forwarded to the Attorney General’s Office***

\*\*\*EVERY ITEM MUST BE COMPLETED LEGIBLY AND IN ITS ENTIRETY\*\*\*

FORM WILL BE PROCESSED ONLY IF IT BEARS THE SIGNATURES OF THE INDIVIDUALS APPROVED BY THE REGISTRY

Facility Information: [ ]  Nursing Facility [ ]  Adult Residential Care Provider

Facility State ID: Enter Facility State ID

Facility Name: Enter Facility Name Facility Phone: Enter Telephone Number

MAC Name: Enter MAC Name Certification#: Enter MAC Certification #

MAC Date of Birth: Enter Date of Birth (Month/Day/Year)

MAC Phone: Enter MAC Telephone Number

MAC Address: Enter Address – City, Street, State, Zip Code

Initial Date Worked: Enter Date (Month/Day/Year

Last Date Worked: Enter Date (Month/Day/Year)

Reason for Termination: Enter the Reason for Termination

Facility Designated Representative Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Enter Date (Month/Day/Year)

Facility Designated Representative Print Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Enter Date (Month/Day/Year

**Email Form To:** **HSS-MAC@LA.GOV** **or;**

**Mail Form To: LDH Health Standards Section**

 **P.O. Box 3767**

 **Baton Rouge, LA 70821**

 **ATTN: MAC Program Manager**

**\*This form or copies of such shall not be given to any unauthorized employee(s) or personnel**