



Thomas Forslund, Director

Governor Matthew H. Mead

Medication Assistance Trainer Agreement

Your status as a certified Medication Assistance Trainer is a privilege extended to you by the Wyoming Department of Health, Developmental Disabilities Section. The continuation of this privilege is dependent upon several factors including an understanding of, and adherence to the following agreements:

1. I understand **I am not an employee of the Developmental Disabilities Section (DDS)** and I will not be compensated by the State of Wyoming for any services rendered in my capacity as a Trainer.
2. I understand **I am not covered under any liability protection** by the State of Wyoming.
3. I understand **I am required to attend mandatory webinar trainings that may occur due to changes in the Medication Assistance Training program.**
4. I understand **I am required to inform the DDS Training Coordinator** by email if I have a class cancellation or any changes to my contact information. I understand I am required to provide a minimum of three (3) days' notice if I am cancelling a class.
5. I understand **I must utilize the entire DDS Medication Assistance Training (MAT) curriculum**, including the manual, quizzes and final exam, roster, and survey as the basis of my training, and I may add to the curriculum, as need dictates.
6. I understand **I can teach the MAT curriculum and issue MAT certificates only if I am in good standing with the DDS.**
7. I understand the ability to utilize my **Medication Assistance Trainer certificate is contingent upon the requirement of being either an active certified DDS provider or an employee of an active certified DDS provider.** I also understand that my Trainer certification is rendered invalid should I be outside these stated requirements for more than a 30-day period.
8. I understand **I will register all of my MAT courses online on the DDS website (2) weeks prior to the class date.**
9. I understand **I am expected to conduct trainings in an environment that is conducive to a meaningful learning experience.**
10. I understand **I am required to present a copy of the MAT manual to my students to keep** with the understanding this manual becomes the property of the student.
11. I understand **upon a student's successful passing of my MAT class, I am required to promptly issue them the DDS paper certificate.** The certificate is the Student's property for them to keep but if a Student loses their certificate that I have trained, **I am responsible for maintaining records of my student MAT completions and re-issuing them a certificate if lost.**
12. I understand **within three (3) business days after the completion of my MAT course I forward to the DDS Training Coordinator** by mail the following three (3) materials:
 1. **DDS student roster** that is legible and completely filled out
 2. **DDS surveys** generated by each student after the training
 3. **DDS original final exams** for each student
13. I understand **my tenure as a Medication Assistant Trainer is dependent on my continued adherence to the conditions stipulated** in this agreement.
14. I understand **DDS has the right to sanction or revoke my Medication Assistance Trainer certification should I be in violation of any conditions stipulated in this agreement.**

My signature acknowledges I have read, understood, and agreed to all stipulations in this agreement.

Trainer Name Printed

Trainer Signature

Date