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**Individual Medication Technician Request For Renewal Application**  
**The request must be completed in full**

Full Name: \_\_\_\_\_

Current Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social Security Number: \_\_\_\_--\_\_\_\_--\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Have you completed the 4-hour clinical update? Circle **Yes** or **No**

\*\*\*Have you repeated the 20-hour Medication Technician Course? Circle **Yes** or **No**

\*\*\* If you have repeated the 20-hour course, the Medication Technician **RENEWAL** application must be submitted by the RN/CM/DN with a class list indicating you have repeated the 20 hour course.