

# DDS or DMH/DCF MAP COORDINATOR CONTACT FORM

Please choose a MAP Coordinator (see organizational chart) in your area/region to have your name placed on a mailing/email list for notification of MAP Trainer/Provider Representative meetings, MAP updates, etc.

To: \_\_\_\_\_, MAP Coordinator

Re: Addition to MAP Trainer/Provider Rep. Mailing List

\*\*\*\*\*

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

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

\_\_\_\_\_

\_\_ Home \_\_ Work

Telephone: \_\_\_\_\_

\_\_ Home \_\_ Work

Email address: \_\_\_\_\_

Attended MAP Overview and/or Trainer session(s) on \_\_\_\_\_



**Medication Administration Program (MAP)  
Approved Trainer Registration Form**

*(Please print all information)*

|                                    |                                |
|------------------------------------|--------------------------------|
| Name:                              | Employer Name:                 |
| Home Address:                      | License #:<br>Expiration Date: |
| Home Phone:                        | Work Phone:                    |
| E-mail Address <i>(optional)</i> : |                                |

\_\_\_\_\_

*From time to time, provider agencies and temporary staffing agencies request that an Approved MAP Trainer list be made available to them. Do you wish to have your name, along with your home address and telephone number, appear on such a list?  
(Please circle response)*

Yes No  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Departments of  
Public Health, Developmental Services, Mental Health, and Children and Families  
Train the Trainer  
Medication Administration Program**

**MAP Trainer Preceptor Form**

I, \_\_\_\_\_, an Approved Medication Administration  
(print name)

(MAP) Preceptor, certify that \_\_\_\_\_ has  
(print name)

observed an entire MAP Certification training conducted by me on \_\_\_\_\_.  
(date)

Signed:

\_\_\_\_\_  
(Approved MAP Trainer Preceptor)

\_\_\_\_\_  
(Approved MAP Trainer Applicant)

Please return completed form to:

Department of Mental Health  
Central Office  
Attn: Melissa Touadjine  
25 Staniford Street  
Boston MA 02114

Fax 617.626.8077