

# OVERDOSE RESPONSE PROGRAM (ORP) TRAINEE APPLICATION FOR CERTIFICATE

Original  
 Renewal

Applicant Name:

\_\_\_\_\_

First
Middle
Last

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

City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Applicant must be at least 18 years old)  
(Month/day/year)

E-mail Address (optional): \_\_\_\_\_ Phone Number (optional): \_\_\_\_\_

Sex (optional):  Male  Female  Not Stated

Race/Ethnicity (optional) check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> White or Caucasian<br><input type="checkbox"/> Asian<br>Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|

Please check which category best describes your reason to receive a certificate:

- Occupation  Volunteer Work  Family Member  Social Experience  Law Enforcement

*I hereby certify that the information contained in this application is complete and accurate to the best of my knowledge.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR ORP USE ONLY:**

Trainee eligible to receive:  Certificate  Prescription for naloxone  Naloxone

Date of Training: \_\_\_\_\_ Location of Training: \_\_\_\_\_

Certificate Serial Number: _____  Certificate Issuance Date: _____  Certificate Expiration Date: _____	<i>Prescription (if applicable):</i>  Prescriber Name: _____  Prescription Number: _____	<i>Naloxone (if applicable):</i>  Naloxone Lot Number: _____  Naloxone Expiration Date: _____  # Doses: _____ <input type="checkbox"/> Intranasal <input type="checkbox"/> Intramuscular  Dispensed by: _____
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ORP Proficiency Quiz for Certificate Renewal