WAOPS Wisconsin Association of Osteopathic Physicians & Surgeons

Anaphylaxis Training Program
Instructor Certification Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

As a certified instructor for the WAOPS Anaphylaxis Training Program, I agree to the following:

- *Teach to the best of their ability*
- *Complete recertification every four years through a state-approved training program*
- *Act professionally while avoiding political, religious, and sales endorsements*
- *Offer the course free of charge and direct all donations to the Dillon Mueller Memorial Fund*
- *Review Package Insert on each epinephrine auto injector & trainer*
- *Provide a $50 administrative fee annually (scholarships available from Dillon Mueller Memorial Fund)*
  - ☐ *I request a scholarship from Dillon Mueller Memorial Fund*

1. I attest that I have attended an approved 'DO It for DILLON' Anaphylaxis Training Program course:

   Date: _____ Location: _____

2. I attest that I assisted an Instructor with a Course *(not required for licensed healthcare professionals):*

   Date: _____ Location: _____

Instructor Recommendation *(not required for licensed healthcare professionals):*

This applicant would be an appropriate instructor for the DO it for Dillon Anaphylaxis Training Program:

Signature: _____ Date: _____

Name (printed): _____

I attest that I have completed this form truthfully:

Signature: _____ Date: _____

Name (printed): _____