

Trainer Number assigned: \_\_\_\_\_ Date assigned: \_\_\_\_\_



agency for persons with disabilities  
*State of Florida*

**MEDICATION ADMINISTRATION TRAINER  
APPLICATION FORM**

Name of Proposed Trainer: \_\_\_\_\_

If this trainer is providing training as an employee of another person or business, name of Medication Administration Training Provider: \_\_\_\_\_

Mailing Address \_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Course: 65G-7 Medication Administration	Classroom hours: No less than 6
65G-7 Prescribed Enteral Formula Administration	Classroom hours: No less than 2
65G-7 Insulin Administration	Classroom hours: No less than 4

I will teach, as provided, without changes:

- APD curriculum 65G-7 Medication Administration – no less than six classroom hours.
- Web-based format (trainer provided, using APD curriculum) – no less than six hours.
- APD curriculum 65G-7 Prescribed Enteral Formula Administration – no less than two classroom hours – not available in Web-based format.
- APD curriculum 65G-7 Insulin Administration – no less than four classroom hours – not available in Web-based format.

\_\_\_\_\_  
Signature of Trainer Applicant Date

All trainers must attend an overview course on Chapter 65G-7, F.A.C. before their application to provide Medication Administration Training is approved. In addition, each trainer must attend an annual update provided by the Agency or their local Region.

Individual has attended and successfully completed an overview course on Ch. 65G-7, F.A.C.

\_\_\_\_\_  
Signature of Agency MCM Date