



TEMPORARY VALIDATION

PRINTED NAME OF MEDICATION ASSISTANCE PROVIDER

**May administer medication via the _____ route to _____
NAME OF CLIENT
for a period of 30 days or less, to allow time for him/her to obtain a validation from an APD
approved Validation Trainer. I have taught this Medication Assistance Provider how to give
this medication by this specific route to ensure client safety.**

Date of Validation

How long will this validation be needed to ensure client receives medication as prescribed?

Printed Name/Signature of MD/RN/LPN

MD/RN/LPN License Number/Expiration Date

Temporary validation is not available for Insulin or Prescribed Enteral Formula Administration, but may be used for Enteral Medication Administration