

Validation Trainer Number assigned: _____ Date assigned: _____



agency for persons with disabilities
State of Florida

**VALIDATION TRAINER
APPLICATION FORM**

Name of Proposed Trainer: _____

Mailing Address: _____

Telephone number: _____

E-mail Address: _____

License Number: _____ Expiration date: _____

To be eligible for approval as a Validation Trainer for Medication Administration or Prescribed Enteral Formula Administration, individuals must be licensed or authorized to practice:

1. Nursing in the State of Florida pursuant to Ch. 464, F.S.; or
2. Medicine as a physician in the State of Florida pursuant to Chs. 458 or 459, F.S.

To be eligible for approval as a Validation Trainer for Insulin Administration, individuals must be licensed or authorized to practice:

1. Nursing, as a Registered Nurse or higher, in the State of Florida pursuant to Ch. 464, F.S.; or
2. Medicine as a physician in the State of Florida pursuant to Chs. 458 or 459, F.S.

All validation trainers must attend an overview course with their Regional MCM on Chapter 65G-7, F.A.C., before their application to provide Validation Training is approved.

Individual has attended and successfully completed a Validation Requirements Overview.

Signature of Agency MCM

Date

In addition, each trainer must attend any subsequent trainings that may be required by APD and provided by their local Region.

I will provide validation training for: 65G-7 Medication Administration
 65G-7 Prescribed Enteral Formula Administration
 65G-7 Insulin Administration

Signature of Validation Trainer Applicant

Date