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:
~~(a) 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