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

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.

____ _________________________

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

APD Form 65G-7.003 A, effective December 2018
Rule 65G-7.003, F.A.C.