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, individuals must:

(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.

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

____ __________________________

Signature of Validation Trainer Applicant Date\

APD Form 65G-7.0035 A, effective December 2018

Rule 65G-7.0035, F.A.C.