

**Support Coordinator In-Service Training Verification**

Instructions: This form must be completed by the Waiver Support Coordinator/Consultant and maintained in his or her file for in-service credit pursuant to chapter 65G-10, F.A.C. Complete the information below and attach all relevant information. The Agency for Persons with Disabilities reserves the right to approve or reject whether and how many in-service training credits will be authorized based only on the information included with this form and supporting documentation. Only one training can be submitted per form.

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| 1. | Title of the course | Click or tap here to enter text. |
| 2. | Name, credentials, and affiliation of the person(s) providing the training. | Click or tap here to enter text. |
| 3. | Include telephone number, email address, and/or mailing address of the person or organization presenting the training. | Click or tap here to enter text. |
| 4. | Synopsis describing the subject matter of the training. | Synopsis attached:  Yes No |
| 5. | The relation the training has with duties of a Waiver Support Coordinator or CDC+ Consultant. | Click or tap here to enter text. |
| 6. | The date and times of the course, not including breaks (e.g., 12/11/2020, 9:00 to 12:00). | Click or tap here to enter text. |
| 7. | Number of Hours spent in the training. | Click or tap here to enter text. |
| 8. | Attach a copy of the syllabus and agenda, if available, and all other training material provided during the course. | Syllabus, agenda, or other material attached.  Yes No |
| 9. | Method of presentation. Check all that apply. | Remote \_\_\_ In-Person \_\_\_  Pre-Recorded \_\_\_ Online \_\_\_ |
| 10. | Proof of Completion of the training, (e.g., Certificate showing course completed). | Proof of Completion attached:  Yes No |

By signing this Support Coordinator In-Service Training Verification form, I am attesting that this form and any attachments hereto, is accurate, and that I am aware that any deliberate misrepresentation or false statement made in the completion of this form may result in denial of any in-service credit.

Signature of Support Coordinator/Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap here to enter text.

**FOR QUALIFIED ORGANIZATION ADMINISTRATION USE ONLY:**

Name of Qualified Organization: Click or tap here to enter text.

Reviewed by Qualified Organization: Yes☐ No☐

Name of Supervisor of Trainee Who Reviewed Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_