



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.

1.	Title of the course	
2.	Name, credentials, and affiliation of the person(s) providing the training.	
3.	Include telephone number, email address, and/or mailing address of the person or organization presenting the training.	
4.	Synopsis describing the subject matter of the training.	Synopsis attached: Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	The relation the training has with duties of a Waiver Support Coordinator or CDC+ Consultant.	
6.	The date and times of the course, not including breaks (e.g., 12/11/2020, 9:00 to 12:00).	
7.	Number of Hours spent in the training.	
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

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:

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: _____