

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
<u>65G-7 Insulin Administration</u>	<u>Classroom hours: No less than 4</u>

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.
- APD curriculum 65G-7 Insulin Administration – no less than four 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