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