agency for persons with disabilities
State of Florida

MEDICATION ADMINISTRATION TRAINING
PROVIDER/COURSE APPROVAL FORM

Name of Proposed Course Provider _____

License Number _____ Expiration Date _____

Mailing Address _____

Telephone number_____ E-mail Address _____

Course Title:_____ Classroom hours:_____

Outline of subject matter content_____
_____
_____
_____
_____
_____
_____
_____

Instructor qualifications:_____
_____
_____
_____

Please attach a syllabus of the proposed course and a list of proposed instructors, including the instructors' names, qualifications, and license numbers.

You must also submit documentation regarding the course learning measures, measurement of comprehension, monitoring of enrollment, participation, and course completion. If this is a web-based course, please include information regarding by which the provider will assure that the stated course hours are consistent with the actual hours required to complete the course. Any changes to the information provided in this application require an updated application and approval of those changes. Please refer to Rule 65G-7.003, F.A.C. for additional information regarding course approval requirements.