agency for persons with disabilities
State of Florida

VALIDATION CERTIFICATE

Name of Applicant

Has been validated as competent to provide

Medication Administration Assistance
For the Routes of Administration Listed on this Certificate

Validation date: _____ *Expiration date:* _____

_____
Signature of validating health care professional

_____
Printed name of validating health care professional

_____
License number and expiration date of validating health care professional

_____
Address of unlicensed direct service provider

_____
Employer of direct service provider, if any

_____
Employer address, if any

Validated Administration Routes Date Signature and License # of Validating Health Care Professional

Oral……_____....._____

Topical……_____....._____

Transdermal……_____....._____

Opthalmic……_____....._____

Otic……_____....._____

Rectal……_____....._____

Inhaled……_____....._____