agency for persons with disabilities
State of Florida

BASIC MEDICATION ADMINISTRATION VALIDATION CERTIFICATE

Name of Applicant to be validated:	Date of Medication Administration Class:
Medication Administration Trainer's Name:	Trainer's Approval Number:

Validation Trainer's Name/APD Trainer Number:		Initials:
Check title: ☐MD ☐APRN ☐LPN ☐RN	License number:	License expiration date:
Validation Trainer's signature: ← (***Must sign)***		
Primary Route Validation Date:	Validation Effective Date:	Validation Expiration Date (12 months from effective date):

I hereby certify the direct care provider demonstrated 100% proficiency at the time skills were validated.

	Primary Route (circle one)			**Inhaled**				**One-time validation, by simulation during training course or with other validation.** For revalidation, bring date forward.		
Route(s)	**Oral**	**Enteral**	**Ophthalmic**	**Inhaler**	**Nasal**	**Nebulizer**	**Rectal**	**Otic**	**Topical**	**Transdermal**
Initials										
Date										

Primary Route Validation Trainer must validate these skills:

- ☐ Applicant has valid Basic Medication Administration Training Certificate for training completed within last 180 days before initial validation
- ☐ Demonstrates the ability to comprehend and follow medication instructions on a prescription label, physician's order, and properly complete a MAR form, including correct transcription from prescription to MAR
- ☐ Demonstrates the ability to obtain pertinent medication information, including the purpose of the medication, its common side effects, and symptoms of adverse reaction to the medications
- ☐ Demonstrates the ability to write legibly and convey accurate information in a manner that ensures health, safety, and wellbeing of clients; comply with medication administration record keeping requirements
- ☐ Demonstrates knowledge of the proper storage, handling and disposal of medications, including special requirements for controlled medications
- ☐ Demonstrates knowledge of requirements for obtaining authorization for assistance with medication administration, authorization for self-administration of medication with supervision, and informed consent for medication administration assistance
- ☐ Demonstrates adequate training on the correct positioning and use of any adaptive equipment or use of special techniques required for the proper administration of medication;
- ☐ Demonstrates the ability to communicate in a manner that permits healthcare providers and emergency responders to adequately and quickly respond to emergencies

Subsequent route validations: (Name, APD Trainer number, signature, initials, license number and expiration date of Validation Trainer required)

Name of Validation Trainer	APD Trainer #	Signature of Validation Trainer	Initials	License #	License expiration date