

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

Address of unlicensed direct service provider

Printed name of validating health care professional

Employer of direct service provider, if any

License number and expiration date of validating health care professional

Employer address, if any

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

Oral....._____

Topical....._____

Transdermal....._____

Ophthalmic....._____

Otic....._____

Rectal....._____

Inhaled....._____