Validating Provider's Name	**MD ARNP RN**
Date of Validation	
Course Curriculum Approval Number	
Course Completion Date	

[ ] Initial Validation
[ ] Validation Renewal; Date of last validation: _____

Direct Care Provider's Name	
Direct Care Provider's Address	
Employer's Name (if applicable)	
Employer's Address (if applicable)	

Please have the Direct Care Provider complete the MAR entry below either from the client's pill bottle label or a copy of one of the client's prescriptions (entry must be legible)

agency for persons with disabilities
State of Florida

Medication Administration Record (MAR)

Name:_____ Month:_____, Y
Allergies: _____

Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Drug Name, Dosage, Route																							
Prescribed By:																							

[ ] Demonstrates the ability to comprehend and follow medication instructions on a prescription label, physician's order, and properly complete a MAR form;

[ ] Demonstrates the ability to administer medication by oral, transdermal, ophthalmic, otic, rectal, inhaled, or topical administration routes;

[ ] Demonstrates the ability to obtain pertinent medication information, including the purpose of the medication, its common side effects, and symptoms of adverse reactions to the medication, either from the package insert that comes from the pharmacy, or a Physician's Desk Reference or other professionally recognized medication resource, and maintaining this information for easy access and future reference;

[ ] Demonstrates the ability to write legibly, convey accurate information, and comply with medication administration record-keeping requirements;

[ ] Demonstrates knowledge of the proper storage and handling of medications;

[ ] Demonstrates knowledge of proper disposal of expired or unused medications;

[ ] Demonstrates knowledge of special requirements relating to storage and disposal of controlled medications;

[ ] Demonstrates knowledge of requirements for obtaining authorizations for assistance with medication administration, authorization for self-administration of medication without supervision, and informed consent for medication assistance; and

[ ] 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.

Route(s) Validated: []Oral [] Otic []Opthalmic [] Transdermal [] Topical [] Rectal [] Enteral [] Inhaled

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

_____ _____

Signature of Validating Healthcare Provider **License Number**