ASSISTED LIVING FACILITY
Alzheimer’s Disease And Related Disorders Training Provider Certification

(Incorporated by reference in rule 58A-5.0194, 58T-1.205, F.A.C., pursuant to s. 429.178, F.S.)

Special instructions: Please read this application carefully. Fill in all the blanks. Return the completed application along with written proof of your eligibility to:
Training Academy on Aging
School of Aging Studies
13301 Bruce B. Downs Blvd.
FMHI – MHC 1300
Tampa, Florida 33612
(813) 974-3414

For agency use only

<table>
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<tr>
<th>Approved</th>
<th>Not Approved</th>
<th>Preapproval</th>
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Trainer # __________ Approval # __________

PART 1: Applicant Contact Information
(The information provided below will be used for all future correspondence)

Name: ________________________________________________________________

Company (if applicable): ______________________________________________

Address: __________________________________________________________________________________________________________

City State Zip code County

Telephone: (_____) ____________________________

Area code Number

Fax: (_____) ____________________________

Area code Number

E-Mail: ________________________________________________________________

Part 2: Applicant Certification
I hereby affirm that all information included in this application is true and correct.

Print or type name of applicant: __________________________________________

Signature of applicant: _________________________________________________

Date: ___________________
APPLICANT CREDENTIALS
For Alzheimer’s Disease and Related Disorders Training

Part 3 - Applicant Credentialing Requirements Checklist

In order to be eligible for certification, you must provide proof of one the following:

- A Master’s degree from an accredited college or university in a health care, human service, or gerontology-related field;

  OR

- A Bachelor’s degree from an accredited college or university, or licensure as a registered nurse, AND one of the following:
  - Proof of 1 year of teaching experience as an educator of caregivers for individuals with Alzheimer’s disease or related disorders; OR
  - Proof of completion of a specialized training program specifically relating to Alzheimer’s disease or related disorders, and a minimum of 2 years of practical experience in a program providing direct care to individuals with Alzheimer’s disease or related disorders; OR
  - Proof of 3 years of practical experience in a program providing direct care to persons with Alzheimer’s disease or related disorders.
**IMPORTANT INFORMATION/INSTRUCTIONS:**

Please send this application along with written proof of eligibility (see above, documentation checklist) to the address on the front of this application. *No application will be accepted without written proof of eligibility.*

Upon receipt of your application, your credentials will be reviewed and you will be sent written notification of the status of your application.

You must be an approved training provider and utilize an approved training curriculum prior to commencing training activities, pursuant to rule 58A-5.0194, F.A.C.

Please note: ANY MATERIALS SUBMITTED WITH THIS APPLICATION WILL NOT BE RETURNED.

DOEA ALF/ADRD-001 (November 2013) 58A-5.0194, 58T-1.205
Part 5 – Training Course Curriculum Checklist

☐ I am submitting my Training Course Curriculum for approval with this application.  
(Note: if checked, a completed “Application for Alzheimer’s Disease or Related Disorders Training Curriculum Certification” must accompany this application).

☐ The Training Course Curriculum/Curricula I will be using has/have been submitted and approved.  
Curriculum Approval #________
Submitted by (Name)  ____________________________
Company (if applicable)  ____________________________
Address  ____________________________
City, State, Zip  ____________________________
Date Submitted  ____________________________

☐ The Training Course Curriculum I will be using has been submitted and approval is pending.
Submitted by (Name)  ____________________________
Company (if applicable)  ____________________________
Address  ____________________________
City, State, Zip  ____________________________
Date Submitted  ____________________________

☐ The Training Course Curriculum I will be using has not been submitted. Note:  
This application will be held pending submittal and approval of Training Course Curriculum:
To be submitted by (Name)  ____________________________
Company (if applicable)  ____________________________
Address  ____________________________
City, State, Zip  ____________________________
Date to be Submitted  ____________________________

NOTICES
1. If your Training Course Curriculum has not been approved, your application for approval will be held until your Training Course Curriculum receives approval.
2. All requests to use copyrighted Training Course Curriculum materials must be accompanied by permission from the author for use.