CONTRACTED HEALTH CARE PRACTITIONER CHECKLIST

Name of Individual or Agency: _____

If Agency, name of individual to provide services: _____

Phone: _____ Alternate Phone: _____

Profession*: _____

Professional License Number: _____ (Attach copy)

School: _____ Date(s) of Event: _____

Indicate when each of the following requirements are completed:

Requirement	Date	Staff Signature
Educational Consultant Agreement completed and approved		
Professional Florida license confirmed as active and valid		
Level 2 background screening completed and passed		
Current CPR Certification		
Signed Statement of Confidentiality Submitted		
Orientation to District medication administration procedures		
Assist in preparation of medications and review of Medication Authorizations		

I _____ affirm that I possess a valid Florida license to practice
Name Printed

_____ and I have completed all of the above requirements.
Profession

Signature: _____ Date: _____

Copy to be retained by:

- School Activities Department
- School Nurse
- Exceptional Education and Student Support Services