

Alabama Board of Athletic Trainers Attestation Form  
Intravenous Access and Intravenous Fluid Administration

Name \_\_\_\_\_ License No. \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

**This form shall be submitted to the Board via email at a [AthleticTrainers@alstateboard.com](mailto:AthleticTrainers@alstateboard.com).**

Athletic Trainers must submit the required documentation to the Board to meet the regulated qualifications for the practice of Intravenous (IV) access and Intravenous (IV) fluid administration as described:

1. The Athletic Trainer must be a licensed athletic trainer within the State of Alabama.
2. IV access and IV fluid administration training must be a minimum of **3 hours** with at least (1) one hour hands-on and (2) two hours instructional and education that included risks and benefits.
3. Approval of supervising physician via the Athletic Trainers' licensure Attestation must be attained before the practice of IV access and IV fluids administration are employed.
4. This Attestation form shall be submitted to the Alabama Board of Athletic Trainers and **written approval** of the Alabama Board of Athletic Trainers must be received before IV access and IV fluid administration are employed.

By signing below, I attest that:

- I do hereby swear under penalty of perjury that the below statements and information contained in this document are true and correct.
- I attest that with this Attestation form I have met the requirements.
- I attest that I have read and understand the Alabama Athletic Trainers' IV Access and IV Fluid Administration Standards and Protocols.
- I do hereby swear that I will not practice IV access and IV fluid administration outside of, or beyond, my scope of training and the practice protocol.
- I attest that I understand that the supervising physician must provide subsequent annual approval to continue performing IV access and IV fluid administration.

\_\_\_\_\_  
Athletic Trainer's Signature

\_\_\_\_\_  
Print Name (Legibly)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisory Physician's Signature

\_\_\_\_\_  
Print Name (Legibly)

\_\_\_\_\_  
Date