**Appendix 2: Annual self-declaration competency assessment**

Date completed: Date returned (office use only):

Name: Job title:

Ward / clinic of work: Email:

Have you been directly involved in any medication errors? YES NO If YES please provide the Datix number and give your reflections on the incident(s)

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**DECLARATION**

I declare I am competent in the areas where I am currently administering medication

Signature………………………………………………….….Date……………..………………………….

Ward manager or clinical lead signature: Date…………………………………………

To be completed and returned by the end of each December annually. Failure to submit forms may result in removal from the Trust band 4 administration database.

E-mail or post completed forms to: Mary-Ann.Pike@salisbury.nhs.uk (Chief Pharmacists Office, Pharmacy)