Appendix 1: Application form for entry onto the trust Band 4 record of Medicine Administration Database

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| **Applicant Details** |
| **Applicant Name:** |  |
| **Email Address:** |  |
| **Extension Number:** |  |
| **Area of intended practice (ward or clinic):** |  |
| **Ward/ Clinical Manager Name:** |  |
| **Email Address:** |  |
| **Extension Number:** |  |

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| **For ward manager / Clinical lead to complete:** I confirm the individual named above has: |
|  |  Initials Date |
|  Medicines administration identified as part of their role and I am prepared to support their development for delegation of medicines administration. |  |
|  As ward manager or clinical lead I accept responsibility for delegating medicines administration to the individual named above. |   |
|  The individual named above has completed a minimum of level 4 foundation degree medicines administration module |  |
|  Completed the relevant trust medication training |  |
| Has completed a minimum of 8 formative assessments with no concerns raised. |  |
| Will complete an annual self-declaration and return to the practice education team.  |  |

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| Signature of Assistant practitioner/Nursing Associate:Signature of ward manager / clinical lead: |  |
|   Signature of Ward Manager/ Clinical Lead |  |