Appendix 2: Annual Self-declaration competency assessment

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| **RENEWAL DETAILS:** |
| **Name:** |  |
| **Job Title** |  |
| **Date Completed** |  |
| **Date returned (office use only):** |  |
| **Ward/ Clinic of work:** |  |
| **Email Address:** |  |
| **Extension Number:** |  |

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| **CURRENT COMPETENCE:** |
|  Have you been involved in any medication errors? |  Yes No |
|  If YES Please provide the DATIX number and give your reflections on the incident(s) in the box below. Please continue on separate sheets if needed: |  DATIX Number: |

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| **DECLARATION:** |
|   I declare I am competent in the areas where I am currently administering medication |  Yes No  |
|  Signature: |  Date: |
| Ward Manager or clinical lead signature: |  Date: |