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

Name: Date:

Email address: Extension number:

Area of intended practice (ward or clinic):

Ward / clinical manager name: Email address:

Extension Number:

For ward manager / clinical lead: I confirm the individual 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 or is a registered nurse professional oversees.  |  |  |
| 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 chief pharmacists office in pharmacy.  |  |  |

**Signature of Band 4 Assistant Practitioners / Nursing Associates:**

**Signature of ward manager / clinical lead:**

(please return completed forms to the chief pharmacists office in pharmacy)

Office use only:

Signed by Chief Pharmacist: Date:

Signed by Deputy Director of Nursing: Date: