

**Medication Competency Declaration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Staff Member:** | |  | | |
|  | | | | |
| **Competency Declaration** | | | | |
| **I confirm that the abovenamed staff member has successfully demonstrated, on at least three occasions, that they have the required knowledge and skills to safely manage and administer medication within our services.**  **Their competency has been assessed through direct observation and detailed discussion as per the Medication Competency Assessment and Observation process.** | | | | |
| **Signed by Manager:** |  | | | |
| **Name:** |  | | | |
| **Role:** |  | | | |
| **Date Signed-Off:** |  | | | |
|  | | | | |
| **Dates of Competency Assessments** | | | | |
| **Date of 1st Assessment:** |  | | **Completed By:** |  |
| **Date of 2nd Assessment:** |  | | **Completed By:** |  |
| **Date of 3rd Assessment:** |  | | **Completed By:** |  |

**Once completed, please retain this form in the individual’s supervision file.**

