Medical Policy and Procedures – Appendix 3

Staff Training Record – Administration of Medicines

Name:

Type of training received:

Date training was completed:

Training provided by [name]:

Trainer's profession and title:

I confirm that…………………………………………………has received the training detailed above and is competent to carry out any necessary treatment.

I recommend that the training is updated every……………………………………….

Trainer's signature:

Date:

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I confirm that I have received the training detailed above.

Staff signature:

Date:

Suggested review date: