**Local Authorisation:**

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| **Service Area for which PGD is applicable:** | | | |
| I authorise the supply/administer medicines in accordance with this PGD to patients cared for in this service area. | | | |
| **Lead Clinician for the service area (Doctor)** | | | |
| **Name:** | **Signature:** | **Designation:** | **Date:** |
|  |  |  |  |
| **E-Mail contact address:** | | | |

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| I agree that only fully competent, qualified and trained professionals are authorised to operate under the PGD. Records of nominated individuals will be kept for audit purposes. | | | |
| **Name** (Lead Professional)**:** | **Signature:** | **Designation:** | **Date:** |
|  |  |  |  |
| **E-Mail contact address:** | | | |

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| **Description of Audit arrangements:** | | | |
| **Frequency of checks:**  **(Generally annually)** |  | **Names of auditor(s):** |  |

**PGDs DO NOT REMOVE INHERENT PROFESSIONAL OBLIGATIONS OR ACCOUNTABILITY.**

**It is the responsibility of each professional to practice only within the bounds of their own competence and in accordance with their own Code of Professional Conduct.**

Note to Authorising Managers: authorised staff should be provided with an individual copy of the clinical content of the PGD and a photocopy of the document showing their authorisation.

I have read and understood the Patient Group Direction. I acknowledge that it is a legal document and agree to supply/administer this medicine only in accordance with this PGD.

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| **Name of Professional** | **Signature** | **Date** |
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