Authorization to Assist with the Self-Administration of Medication

This certifies that

_____

(Employee Name)

Is authorized to Assist with the Self-Administration of Medication

without direct supervision

Declaration:

By issuing this voucher, I confirm that the above named individual has completed all required components in accordance with Delaware Policies and Procedural Guidelines. I understand that by issuing this voucher on behalf of my Agency, I am responsible for ensuring compliance with the aforementioned Policies & Guidelines of the Delaware Assistance with Medication Program.

_____

Date of Class

_____

Date Medication Passes Completed

ISSUED BY

_____ _____

AGENCY DESIGNEE **AGENCY NAME AND ADDRESS**