Staff training record – administration of medicines

Name	
Type of training received	
Date of training completed	
Training provided by	
Profession and title	

I confirm that the person named above has received the training as detailed and has demonstrated competence to carry out any necessary treatment. I recommend that the training is updated by _____.

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____