

**Appendix 1**

**Healthcare Professional Agreement to Supply Medicine(s) Under Patient Group Direction**

|  |  |  |
| --- | --- | --- |
| **I:** |  | (Insert name) |
| **Working within:** |  | e.g. Area, Practice |

Agree to supply the medicine(s) contained within the following Patient Group Direction:

**Patient Group Direction For The Supply Of The Desogestrel Progestogen Only Contraceptive Pill By Approved Healthcare Professionals Working Within NHS Grampian, Highland, Orkney, Shetland, Tayside And Western Isles**

I have completed the appropriate training to my professional standards enabling me to supply the medicine(s) under the above direction. I agree not to act beyond my professional competence, nor out with the recommendations of the direction.

|  |  |
| --- | --- |
| **Signed:** |  |
| **Print Name:** |  |
| **Date:** |  |
| **Profession:** |  |
| **Professional Registration number/PIN:** |  |