

**Individual authorisation (Appendix 1)**

**PGD FOR THE SUPPLY OF FLUCLOXACILLIN CAPSULES OR ORAL SOLUTION BY COMMUNITY PHARMACISTS UNDER THE “NHS PHARMACY FIRST SCOTLAND” SERVICE**

***This PGD does not remove professional obligations and accountability.***

It is the responsibility of each professional to practice within the bounds of their own competence and in accordance with the General Pharmaceutical Council Standards for Pharmacy Professionals.

Authorised staff should be provided with an individual copy of the clinical content of the PGD and a copy of the document showing their authorisation.

This authorisation sheet should be retained to serve as a record of those practitioners authorised to work under this PGD.

I have read and understood the PGD authorised by each of the NHS Boards I wish to operate in and agree to provide flucloxacillin capsules or oral solution only in accordance with the specific PGD.

Name of Pharmacist GPhC Registration Number

Normal Pharmacy Location

|  |  |  |
| --- | --- | --- |
| **Name of Pharmacy** | **Contractor Code** | **Health Board** |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |

**(Only one Pharmacy name and contractor code is required for each Health Board area where appropriate. If you work in more than 3 Health Board areas, please use additional forms.)**

Please indicate your position within the pharmacy by ticking one of the following:

Locum [ ]  Employee [ ]  Manager [ ]  Owner [ ]

Signature Date

**Please complete form, sign and send to each Health Board you work in.** Email and postal addresses are given overleaf.