

Staff training record - administration of medical treatment

Name:

Type of training received:

Date training completed:

Training provided by:

I confirm that _____ has received the training
detailed above and is competent to carry out any necessary treatment.

Trainer's signature:

Date:

Name (print):

I confirm that I have received the training detailed above.

Signature of member of staff:

Position:

Name (print):

Date:

Suggested review date: