|  |  |
| --- | --- |
| NHS Greater Glasgow & ClydePatient Group Direction (PGD) forHealth Care Professionals |  |
| **Shingrix** |

**Local Authorisation:**

|  |
| --- |
| **Service Area for which PGD is applicable:** |
| I authorise the supply/administer medicines in accordance with this PGD to patients cared for in this service area. |
| **Lead Clinician for the service area (Doctor)** |
| **Name:** | **Signature:** | **Designation:** | **Date:** |
|  |  |  |  |
| **E-Mail contact address:** |

|  |
| --- |
| I agree that only fully competent, qualified and trained professionals are authorised to operate under the PGD. Records of nominated individuals will be kept for audit purposes. |
| **Name** (Lead Professional)**:** | **Signature:** | **Designation:** | **Date:** |
| **Emma J Finlay** | \\xggc-vrtl-04\HOME3$\FINLAEM678\Emma Signature.jpg | **Lead Nurse****Immunisation Delivery****Public Health** | **17/1/24** |
| **E-Mail contact address:** |

|  |
| --- |
| **Description of Audit arrangements:** |
| **Frequency of checks:** **(Generally annually)** |  | **Names of auditor(s):** |  |

**PGDs DO NOT REMOVE INHERENT PROFESSIONAL OBLIGATIONS OR ACCOUNTABILITY.**

**It is the responsibility of each professional to practice only within the bounds of their own competence and in accordance with their own Code of Professional Conduct.**

Note to Authorising Managers: authorised staff should be provided with an individual copy of the clinical content of the PGD and a photocopy of the document showing their authorisation.

I have read and understood the Patient Group Direction. I acknowledge that it is a legal document and agree to supply/administer this medicine only in accordance with this PGD.

|  |  |  |
| --- | --- | --- |
| **Name of Professional** | **Signature** | **Date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |