

**DELEGATION FORM**

Facility \_\_\_\_\_ MAC Worker \_\_\_\_\_

**BY SIGNING THIS FORM, I ACKNOWLEDGE COMPLETION OF ALABAMA BOARD OF NURSING APPROVED MAC I AND MAC II TRAINING. I WILLINGLY ACCEPT THE RESPONSIBILITY TO ASSIST WITH MEDICATION ADMINISTRATION AND OTHER DELEGATED NURSING TASKS.**

**MAC Workers Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Date MAC I Completed** \_\_\_\_\_

<b>DATE MAC II COMPLETED</b> (Date Competency of Delegated Nursing Tasks Verified by MAS Nurse OR Date of completion of 8 hour of MAC II training)	<b>DATE DELEGATION SUSPENDED</b> (Note Reason for Suspension of Delegated Nursing Tasks On Back)	<b>DATE DELEGATION STARTS</b>	<b>DELEGATING MAS RN/LPN SIGNATURE AND DATE</b>

**By signing this form, I acknowledge I am a MAS Nurse with current certification AND I accept/acknowledge the current MAC Certification of the person named above. I agree to provide supervision of the unlicensed assistive person (MAC Worker) named above.**

**DELEGATION FORM**

**FACILITY** \_\_\_\_\_ **MAC Worker** \_\_\_\_\_

**OTHER DELEGATING NURSES:**

By signing this form, I acknowledge I am a MAS Nurse with current certification. I have verified the MAC Worker noted above is competent regarding the 7 rights of med administration, med error reporting documentation on the MAR, MAC Call Log and Controlled Substance accountability procedures. I agree to provide supervision of the unlicensed assistive person (MAC Worker) named above.

**THE NEW MAS NURSE MUST DOCUMENT ON THE SKILLS VERIFICATION FORM, “COMPETENCY VERIFICATION ON (Date) BY (Name of MAS) accepted. The New MAS Nurse must sign, date and initial the skills check sheet.”**

DELEGATING MAS RN/LPN SIGNATURE	DATE ALL DELEGATED NURSING TASKS VERIFIED	INITIALS

DATE	MAS RN/LPN COMMENTS/NOTES	INITIALS