

NURSE DELEGATION: ASSUMPTION OF DELEGATION

1. CLIENT NAME	2. DATE OF BIRTH	3. ID/SETTING (OPTIONAL)
4. FACILITY OR PROGRAM NAME (OPTIONAL)		5. TELEPHONE NUMBER
6. REASON/DATES FOR ASSUMING DELEGATION		
I agree that I know the client through my assessment, the plan of care, the skills of the nursing assistant, and the delegated task(s). I agree to assume responsibility and accountability for the delegated task(s) and to perform the nursing supervision. I have informed the client and/or authorized representative of this change. I have informed the nursing assistant, case manager and client of this change.		
7. ASSUMING RND SIGNATURE		8. DATE

DSHS 13-678B (REV. 01/2007)

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078.

COPY IN CLIENT CHART AND RND FILE

INSTRUCTIONS – NURSE DELEGATION: ASSUMPTION OF DELEGATION

All fields are required unless indicated “**OPTIONAL**”.

1. Client Name: Enter ND client’s name (last name, first name).
2. Date of Birth: Enter ND client’s date of birth (month, day, year).
3. ID Setting: OPTIONAL – Enter client’s ID number as assigned by your business OR enter settings “AFH”, “BH”, DDD Program, “In-home”.
4. Facility or Program Name: OPTIONAL – Enter name of facility/program contact.
5. Telephone Number: OPTIONAL – Enter telephone number of facility/program contact including area code.
6. Reason/Dates for Another RND to Assume Delegation: Enter reason other RND rescinded and the date you assume responsibility for delegation.
7. & 8. Assuming RND Signature and Date: Sign and date your signature.