# Nurse Delegation: Assumption of Delegation

<table>
<thead>
<tr>
<th>1. CLIENT NAME</th>
<th>2. DATE OF BIRTH</th>
<th>3. SETTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. FACILITY OR PROGRAM NAME</td>
<td>5. TELEPHONE NUMBER</td>
<td></td>
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</table>

| 6. REASON FOR ASSUMING DELEGATION |

I agree that I know the client through my assessment, the plan of care, the skills of the Long Term Care Worker(s) (LTCW), 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 LTCW, case manager, and client of this change.

7. RND SIGNATURE | 8. DATE

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

**DISTRIBUTION:** Copy in client chart and in RND file

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**Instructions for Completing 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”, “ALF”, 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 **Reason/ Dates for Another RND to Assume Delegation:** Enter reason other RND rescinded and the date you assume responsibility for delegation.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. **Assuming RND Signature and Date:** Sign and date your signature.