Washington State Department of Social & Health Services
Transforming lives

Nurse Delegation: Assumption of Delegation

1. CLIENT NAME	2. ACES ID	3. DATE OF BIRTH	4. SETTING
5. FACILITY OR PROGRAM NAME			6. TELEPHONE NUMBER
7. 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.			
8. RND SIGNATURE			9. DATE

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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DSHS 13-678B (REV. 09/2021)

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. ACES ID: Enter client's ACES Identification number.
3. Date of Birth: Enter ND client's date of birth (month, day, year).
4. ID Setting: OPTIONAL – Enter client's ID number as assigned by your business OR enter settings "AFH", "ALF", DDA Program, "In-home".
5. Facility or Program Name: OPTIONAL – Enter name of facility/program contact.
6. Telephone Number: OPTIONAL – Enter telephone number of facility/program contact including area code.
7. Reason/Dates for Another RND to Assume Delegation: Enter reason other RND rescinded and the date you assume responsibility for delegation.

8. and 9. Assuming RND Signature and Date: Sign and date your signature.

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