STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Office for Citizens with Developmental Disabilities

PHYSICIAN DELEGATION FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENTS

Participant's NAME: **Medicaid Number:**	**DATE:**
PROVIDER AGENCY NAME:	**PHONE NO:**
EMPLOYEE NAME: (One Name Per Page)	

MEDICATION / TREATMENT	DOSAGE / SITE	INSTRUCTIONS

I have provided the above named employee, of the named Medicaid service provider agency, with specific training and instructions concerning the administration of the medication(s) and medical treatment(s) listed. This employee is acting under my authority.

_____ _____
DELEGATING PHYSICIAN'S SIGNATURE **DATE**

PHYSICIAN'S NAME:			
ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE: ( ) _____ _____**

I have been instructed concerning administration of the medication(s) and medical treatment(s) described above, and agree to administer only these medications and treatments and to do so according to the instructions given.

_____ _____
EMPLOYEE'S SIGNATURE **DATE**

NOTE: This form is valid only until there is any change in the approval granted herein. Changes in authorized attendant, medication, dosage, treatment, or instructions require the completion of a new form prior to implementation of the change.