**Staff Proxy Access Request Form**

Application to add/remove care home staff proxy access for online ordering of repeat medication

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1** | | Add access ¨ | | Remove access ¨ | | | | |  |
| **Section 2** | | **To be completed by the Care Home Lead** | | | | | | |  |
| Care Home address | | |  | | Postcode | | |  | |
| Staff name | | |  | | Staff date of birth | | |  | |
| Individual / Staff mobile phone number | | | |  | | | | | |
| Staff **NHS email** (Not shared mailbox) | | | |  | | | | | |
|  | | | | | | | | | **Tick** |
| ID verification | | I confirm I have verified the identity of the named Care Home staff member | | | | | | |  |
| IG training | | I confirm that this staff member has completed the required level of information governance training as identified in the Data Sharing Agreement | | | | | | |  |
| **Add** proxy access | | I confirm that this member of staff is currently employed by our Care Home and proxy access to all residents’ records should be approved | | | | | | |  |
| **Remove** proxy access | | I can confirm that this member of staff has now left our Care Home and proxy access to all residents’ records should be removed | | | | | | |  |
| Care Home Lead Name | |  | | | | | | |  |
| Care Home Lead Signature | |  | | | | Date |  | | |
| **Section 3** | | **To be completed by the Care Home staff member** | | | | | | | **Tick** |
| I have read and understood the information leaflet provided about online access and will treat the resident’s information as confidential | | | | | | | | |  |
| I understand my responsibility for safeguarding sensitive medical information | | | | | | | | |  |
| I will be responsible for the security of the information that is seen or downloaded | | | | | | | | |  |
| I will contact the GP Practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the resident | | | | | | | | |  |
| If I see information in the record that is not about the resident, or is inaccurate, I will contact the GP Practice as soon as possible. I will treat any information which is not about the resident as being strictly confidential. | | | | | | | | |  |
| I understand that the GP Practice may not be able to offer me these services due to any reasons, such as concern that the information could cause harm to the resident’s physical / mental health or where there is reference to third parties. | | | | | | | | |  |
| I understand the GP Practice has the right to remove online access for anyone that does not use this service responsibly | | | | | | | | |  |
| Staff member Signature |  | | | | | Date |  | | |

**IMPORTANT:**

**Please attach a list of residents that this member of staff will order medication for**

|  |  |  |  |
| --- | --- | --- | --- |
| **For GP Practice use only** | | | |
| Method of verification | Vouching – by Care Home Manager | |  |
|  | Other (please state) | |  |
| Authorised and completed – Name |  | Date |  |
| Signature |  |  |  |
| Level of access enabled | Medication requests | |  |
|  | Appointment booking | |  |
|  | Completing questionnaires | |  |
|  | View summary care record | |  |
|  | Coded or full record | |  |
|  | Detailed coded record | |  |
|  | Full clinical record | |  |
|  | Full record with coded record before review date | |  |