This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practise under it. The most recent and in date final signed version of the PGD should be used.

PATIENT GROUP DIRECTION (PGD)

For the administration of intramuscular (IM) medroxyprogesterone acetate (DMPA) injection (150mg/1ml) in BPAS Clinics.

Version Number 3.0

Change History	
Version and Date	Change Details
Version 1.0 *August 2020*	New template *Version 1.0 approved for use in BPAS 04/11/2020.*
Version 1.1 *November 2020*	Minor rewording and highlighting of contents cautions section relating to individuals for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan. Acute porphyria and hypertension with vascular disease added as exclusion criteria. *Version 1.1 approved for use in BPAS 21/12/2022. Note that clients with acute porphyria are already excluded from treatment at BPAS.*
Version 1.1 *May 2023*	Expiry date extended to full 3 year term from original version authorisation in November 2020.
Version 2.0 *August 2023*	BPAS suitability criteria added to exclusions Arrangements for referral for medical advice section added Addition of administration after day 5 of a cycle in off-label section Age limit of 50 added into duration of treatment where no risks identified Additional information entered into drug interactions section Additional information to management and reporting procedure for adverse reactions so more specific to BPAS Additional information added to records to be kept section and made more specific to BPAS.
Version 2.1 *October 2023*	Reworded section on cervical and breast cancer risk, in line with updated FSRH guidance. Updated references.
Version 2.1 *January 2024*	PGD expiry date changed from 31/10/2026 to 31/07/2026 to align with SPS PGD template expiry. No other changes to PGD content. Version number unchanged.
Version 2.2 *August 2024*	Statement added regarding a suggested link between the prolonged use of medroxyprogesterone acetate and a small increased risk of intracranial meningioma in line with FSRH statement. Added exclusion of meningioma as per SPC. Updated references. Updated SLWG.
Version 3.0 *January 2026*	Planned end of life review. Reflects changes in UKMEC (2025). Updated reference from FSRH to CoSRH. Minor rewording to align the RH PGDs content, and update terminology. Update SLWG and references.

N.B. Review and update may occur prior to this period if national guidance changes or legal or clinical issues arise.

BPAS PGD Organisational Authorisations:

This PGD is not legally valid until it has had the relevant organisational authorisations below.

Name	Job title and organisation	Signature	Date
Mary Sexton	BPAS Clinical Director		26/02/2026
Dr Nigel Acheson	BPAS Medical Director		26/02/2026
Kalpesh Thakrar	BPAS Deputy Chief Pharmacist		04/03/2026

Authorising Body:

Dr Fiona Lemmens	Executive Clinical Director, Cheshire and Merseyside ICB		06/04/2026

Responsible person who has approved this PGD on behalf of BPAS

Name: Heidi Stewart

Position: BPAS Executive Chair

Signature: 

Date: 26/02/2026

Glossary	
BPAS	British Pregnancy Advisory Service
BMI	Body Mass Index
BLS	Basic life support
BNF	British National Formulary
CoSRH	College of Sexual and Reproductive Health
DMPA	Medroxyprogesterone acetate
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MHRA	Medicines Health Regulatory Agency
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
SmPC	Summary of medicinal product characteristics
STI	Sexually transmitted infection
VTE	Venous thromboembolism

PGD DEVELOPMENT GROUP

Date PGD template comes into effect:	1st May 2026
Review date:	1st November 2028
Expiry date:	30th April 2029

This PGD template has been peer reviewed by the Reproductive Health PGDs Short Life Working Group (SLWG) in accordance with their Terms of Reference. It has been approved by the College of Sexual and Reproductive Health (CoSRH) College of Sexual and Reproductive Health (CoSRH) in January 2026

Note the working group and approving organisation(s) agreement to the content only applies to the national template and does not extend to any local adaptations made to any of the content which are solely the responsibility of the organisation authorising the PGD. The most up to date version of the template is available from the SPS national PGD, protocol and written instructions templates webpage.

Name or Role	Position
Alison Crompton	Community pharmacist
Bola Sotubo	NHS North East London ICB pharmacist
Carmel Lloyd	Royal College of Midwives (RCM)
Dr Cindy Farmer	Senior Vice President, Professional Learning and Development, College of Sexual and Reproductive Healthcare (CoSRH)
Clare Livingstone	Royal College of Midwives (RCM)
Dipti Patel	Local authority pharmacist
Emma Anderson	Centre for Postgraduate Pharmacy Education (CPPE)
Heather Randle	Royal College of Nursing
Julia Hogan	Clinical Nurse Specialist
Kate Devonport	National Unplanned Pregnancy Association (NUPAS)
Kirsty Armstrong	National Pharmacy Integration Lead, NHS England
Lisa Knight	Community Health Services pharmacist
Michelle Jenkins	Clinical Nurse Specialist Sexual Health Blackpool Teaching Hospitals, and member of Courses and CPD Committee, College of Sexual and Reproductive Healthcare (CoSRH)
Portia Jackson	Lead Pharmacist iCaSH, Cambridgeshire Community Services
Rachel Logan	Senior Pharmacist, BPAS
Tanya Lane	CoSRH Registered Trainer MSI Reproductive Choices
Jo Jenkins	Associate Director Medicines Governance, Medicines Use and Safety, Specialist Pharmacy Service
Kieran Reynolds	Advanced Specialist Pharmacist, Medicines Governance, Medicines Use and Safety, Specialist Pharmacy Service
Rosie Furner (Working Group Co-Ordinator)	Advanced Specialist Pharmacist, Medicines Governance, Medicines Use and Safety, Specialist Pharmacy Service
Sandra Wolper	Out of Hospital Care Lead, Medicines Use and Safety, Specialist Pharmacy Service

Characteristics of staff authorised to use this PGD:	
Qualifications and professional registration	Current contract of employment with BPAS Registered healthcare professional (HCP) listed in The Human Medicines Regulation 2012, Schedule 16 Part 4 legislation as able to practice under Patient Group Directions.
Initial training	The registered healthcare professional authorised to operate under this PGD must have undertaken appropriate education and training and successfully completed the competencies to undertake clinical assessment of patients ensuring safe provision of the medicines listed in accordance with local policy: • Must be familiar with the medicine and observant to changes in the BNF and Summary of Product Characteristics (SmPC) • Pharmacological knowledge relating to the administration and supply of the medicine, its uses, contraindications, dosage and adverse effects. • Must have completed CoSRH 'Essential Contraception for Abortion Care Providers' training or equivalent. Essential Contraception for Abortion Care Providers | CoSRH • Must have completed BPAS in-house contraception training https://bpas.kallidus-suite.com/learn/ • Individual must have completed BPAS Essentials of Contraception interactive session • Must be competent in the administration of adrenaline for anaphylaxis and have up to date Basic Life Support (BLS) skills as a minimum Individual has undertaken appropriate training for working under PGDs for the supply and administration of medicines: • Recommended training - eLfH PGD elearning programme • Must have completed BPAS in-house PGD training package https://bpas.kallidus-suite.com/learn/ Must have completed required BPAS training (including updates) in safeguarding children and vulnerable adults in line with BPAS policy: BPAS Safeguarding Adults at Risk policy. BPAS Safeguarding Children and Young People policy.
Competency Assessment	• Individuals operating under this PGD must be assessed as competent (see appendix A) or complete a self-declaration of competence for contraception supply. • Staff operating under this PGD are encouraged to review their own competency using the NICE Competency Framework for Health Professionals using Patient Group Directions
Ongoing training and competency	• Individuals operating under this PGD are personally responsible for ensuring they remain up to date with the use of all medicines and guidance included in the PGD - if any training needs are identified these should be addressed and further training provided as required. • Practitioners must complete 3-yearly BPAS PGD Theory Refresher training and competency assessment as per BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines

	• Practitioners must ensure they remain up to date with relevant clinical skills, management of anaphylaxis, BLS (as a minimum), with evidence of continued professional development • Practitioners are responsible for maintaining their competency to work under this PGD
The decision to supply any medication rests with the individual registered health professional who must abide by the PGD and any associated organisational policy.	

Clinical condition or situation to which this PGD applies:	
Clinical condition or situation to which this PGD applies	Contraception
Criteria for inclusion	• Individual (age from menarche to 50 years) presenting for contraception. • Informed consent given.
Criteria for exclusion	• Informed consent not given. • Individuals under 16 years of age and assessed as not competent using Fraser Guidelines. • Individuals 16 years of age and over and assessed as lacking capacity to consent. • Established pregnancy. Note - risk of pregnancy with a negative pregnancy test is not an exclusion. • Known hypersensitivity to an active ingredient or to any constituent of the product – see the individual Summary of Product Characteristics which can be accessed on the EMC website • Unexplained vaginal bleeding suspicious of a serious medical condition present before commencing the method. • Acute porphyria • Metabolic bone disease • Post-partum (0 to <6 weeks) with other risk factors for venous thromboembolism (VTE) • Major surgery (initiation) NB: Major surgery includes major elective surgery (>30 minutes' duration) and all surgery on the legs, or surgery which involves prolonged immobilisation of a lower limb. • Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies) • Known chronic kidney disease (CKD) (all stages) • Positive antiphospholipid antibodies **Cardiovascular disease** • Current or past history of ischaemic heart disease, vascular disease, stroke or transient ischaemic attack. • Individuals with multiple risk factors for cardio-vascular disease (such as smoking, diabetes, hypertension, obesity (BMI>30kg/m2) and dyslipidaemias) • Hypertension with vascular disease. • Active thromboembolic disease • History of VTE or current VTE (on anticoagulants) • Individuals with multiple risk factors (defined as more than one risk factor) for VTE are excluded. Clinical judgement should be applied and advice from a prescriber sought. Examples of VTE risk factors include (but not exclusively) ○ family history of VTE,

	○ immobility, ○ BMI> 35kg/m2, ○ superficial VTE, ○ ovarian and endometrial cancer, ○ inflammatory bowel disease, ○ sickle cell disease **Cancers** • Currently being treated or completed treatment for breast cancer • Malignant liver tumour (hepatocellular carcinoma) • History / diagnosis of meningioma. **Gastro-intestinal Conditions** • Severe hepatic impairment. • Known severe (decompensated) cirrhosis • Benign liver tumour (hepatocellular adenoma) **Interacting medicines** – – see current British National Formulary (BNF) or individual product SmPC which is available on the EMC website
Cautions including any relevant action to be taken	• If the individual is less than 16 years of age an assessment based on Fraser guidelines must be made and documented. • If the individual is less than 13 years of age, the healthcare professional should speak to local safeguarding lead and refer to the policy Safeguarding Children and Young People • Discuss with appropriate medical/independent non-medical prescriber any medical condition or medication of which the healthcare professional is unsure or uncertain • Individuals aged under 18 years, should not use IM DMPA first line for contraception because of its effect on bone mineral density. IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. • Individuals of any age with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DPMA – IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include: ○ Alcohol abuse and/or tobacco use ○ Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids ○ Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia ○ Previous low trauma fracture ○ Family history of osteoporosis ○ CKD • Medication should not be re-administered pending examination if there is a sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should not be re-administered. • **Offer Long Acting Reversible Contraception (LARC) to all individuals in particular those with medical conditions for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan.** • **If an individual is known to be taking a medication which is known to be harmful to pregnancy a highly effective form of contraception**

	is recommended. Highly effective methods include the LARC methods: IUD and implant. If a LARC method is unacceptable/unsuitable and IM-DMPA is chosen then an additional barrier method of contraception is advised. See CoSRH statement: Contraception for women using known teratogenic drugs (Feb 2018) FSRH.
Action to be taken if the individual is excluded or declines treatment	• Explain the reasons for exclusion to the individual and document in the consultation record. • Record reason for declining treatment in the consultation record. • Where required refer the individual to a suitable health service provider if appropriate and/or provide them with information about further options.

Description of treatment:	
Name, strength and formulation medicine	Medroxyprogesterone Acetate 150 mg in 1 mL Injection (vial/pre-filled syringe)
Legal category	POM
Route or method of administration	Intramuscular injection (IM) **Advice for administration:** • Follow manufacturers' guidance for administration • Shake the syringe/vial vigorously before administration • Deep intramuscular injection into the gluteal (preferred) or deltoid muscle • Ensure that the full contents of the syringe/vial is administered • Do not massage the site after the administration of the injection
Off-label use	Best practice advice given by College of Sexual and Reproductive Healthcare (CoSRH) is used for guidance in this PGD and may vary from the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website This PGD includes inclusion criteria and dosage regimen which are outside the market authorisation for many of the available products but which are included within CoSRH guidance: • Can be administered after day 5 of a cycle • Can be administered between 10-14 weeks. Refer to CoSRH guidance for administration after 14 weeks. • Administration after five days postpartum if not breast feeding/before six weeks postpartum if breast feeding. CoSRH guidance supports the use of IM DMPA any time after childbirth for both breastfeeding and non-breastfeeding individuals (providing risk factors for VTE allow) Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected medicines for use lies with pharmacy/Medicines Management. Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/parent/carer that the medicine is being

	offered in accordance with national guidance but that this is outside the product licence.
Dose and frequency of administration	• Single IM injection (150mg/1ml) on day 1-5 of the menstrual cycle with no need for additional protection. • IM DMPA can be started at any time after day 5 if it is reasonably certain that the individual is not pregnant. Additional precautions are then required for 7 days after starting and advise to have follow up pregnancy test at 21 days after last UPSI. • When starting or restarting IM DMPA as quick start after levonorgestrel emergency contraception, additional contraception is required for 7 days and follow up pregnancy test required no sooner than 21 days after most recent UPSI. • In line with CoSRH guidance, individuals should delay starting or restarting hormonal contraception for 5 days following use of ulipristal acetate for emergency contraception. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised for a further 7 days and follow up pregnancy test required no sooner than at 21 days after most recent UPSI. • Can be started any time after childbirth. If started after 21 days additional barrier method / abstinence required for 7 days. • IM DMPA dose should be repeated 13 weeks after the last injection. • If required a repeat injection can be given up to 14 weeks after the previous dose with no additional contraceptive precautions. • If required on an occasional basis, IM DMPA injection may be repeated as early as 10 weeks after the last injection. • If the interval from the preceding injection is greater than 14 weeks the injection may be administered/supplied - the professional administering the injection should refer to FSRH current guidelines- Progesterone only injectables for advice on the need for additional contraception and pregnancy testing. • For guidance on changing from one contraceptive method to another, and when to start after an abortion and postpartum, refer to CoSRH - Switching or Starting Methods of Contraception and CoSRH Clinical Guideline: Contraception after Pregnancy
Duration of treatment	For as long as individual requires IM DMPA and has no contraindications to its use. **Note** - In individuals of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use every 2 years. In particular, in individuals with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DPMA – IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include: • Alcohol abuse and/or tobacco use • Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids • Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia • Previous low trauma fracture • Family history of osteoporosis • CKD **If no risks are identified then it is safe to continue IM DMPA for longer than 2 years until the age of 50.**

Quantity to be supplied	Single dose is to be administered per episode of care.
Storage	Medicines must be stored securely according to national guidelines, in line with the BPAS Medicines Management policy Medicines Management Policy and as detailed in the SmPC which can be accessed on the EMC website
Drug interactions	The efficacy of IM DMPA is **not** reduced with concurrent use of enzyme-inducing drugs. All concurrent medications, including those purchased should be considered for interactions. A detailed list of drug interactions is available in the individual product SmPC, which is available from the electronic Medicines Compendium website www.medicines.org.uk the BNF www.bnf.org and, as this PGD supports the administration of hormonal contraception, FSRH CEU Guidance: Drug Interactions with Hormonal Contraception https://www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-drug-interactions-with-hormonal/ Refer to a prescriber if any concern of a clinically significant drug interaction.
Identification and management of adverse reactions	A detailed list of adverse reactions is included in the individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website and the BNF The following possible adverse effects are commonly reported with IM DMPA (but may not reflect all reported adverse effects): • Headache, dizziness • Disturbance of bleeding patterns • Changes in mood • Weight change • Breast tenderness • Loss of libido • Abdominal discomfort or distension, nausea • Alopecia, acne, rash • Genitourinary tract infection • A delay of up to 1 year in the return of fertility after discontinuation of IM or SC DMPA. • Association with a small loss of bone mineral density which is recovered after discontinuation of the injection • The available evidence suggests a possible association between current or recent use of hormonal contraception (including progestogen-only injectables) and a small increase in risk of breast cancer; absolute risk remains very small. • There is a weak association between cervical cancer and use of DMPA for 5 years or longer. Any increased risk appears to reduce with time after stopping and could be due to confounding factors. • Individuals should be advised that evidence suggests a link between the prolonged use of medroxyprogesterone acetate and a small increased risk of intracranial meningioma requiring surgery.
Additional facilities and supplies	• Access to working telephone • Suitable waste disposal facilities • Immediate access to in-date anaphylaxis kit (IM adrenaline 1:1000)

Management and reporting procedure for adverse reactions	• Healthcare professionals and individuals/carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme on: http://yellowcard.mhra.gov.uk • Record all adverse drug reactions (ADRs) in the individual's clinical record. • Report via organisation incident policy: InPhase
Written information and further advice to be given to the individual or carer	• Provide manufacturer's information leaflet (PIL) provided with the original pack. • Explain mode of action, side effects, risks and benefits of the medicine • Offer condoms and advice on safer sex practices and possible need for screening for sexually transmitted infections (STIs) • Ensure the individual has contact details of local service/sexual health services. • Advise there may be a delay of up to 1 year in the return of fertility after discontinuation of IM or SC DMPA.
Follow-up advice to be given to the individual or carer	• The individual should be advised to seek medical advice in the event of an adverse reaction. • Individual to seek further advice if they has any concerns.

Records to be kept	The following must be recorded in the patient records in line with the BPAS' Record Keeping policy Record Keeping, using black ink if written:
	• The consent of the individual and
	  ○ If individual is under 13 years of age record action taken
	  ○ If individual is under 16 years of age document capacity using Fraser guidelines.
	  ○ If individual is under 16 years of age and not competent, record action taken
	  ○ If individual over 16 years of age and not competent, record action taken
	• If individual not treated under PGD record action taken
	• Name of individual, address, patient BPAS identification number, date of birth
	• Relevant past and present medical and sexual history, including smoking status and family history.
	• Relevant medication history (to include over the counter, herbal medications, supplements and recreational drug use)
	• Any known allergies and nature of reaction
	• Name of registered health professional operating under the PGD
	• Name of medication administered
	• Date of administration
	• Dose and site of administration
	• Batch number and expiry date in line with BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines
	• Advice given, including advice given if excluded or declines treatment
	• Individual has been advised on the date/s for next appointment as required
	• Details of any adverse drug reactions and actions taken
	• Advice given about the medication including side effects, benefits, and when and what to do if any concerns
	• Any referral arrangements made
	• Any administration outside the terms of the product marketing

	authorisation • Recorded that administration is via Patient Group Direction (PGD) Records should be signed and dated (or a password-controlled e-records) and securely kept for a defined period in line with local policy. All records should be clear, legible and contemporaneous. A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy. All records should be kept in line with NHS England Records Management Code of Practice. This includes individual data, master copies of the PGD and lists of authorised practitioners.

References and other source material:

Key references (accessed December 2025)	• Electronic Medicines Compendium http://www.medicines.org.uk/ • Electronic BNF https://bnf.nice.org.uk/ • NICE Medicines practice guideline "Patient Group Directions" https://www.nice.org.uk/guidance/mpg2 • Faculty of Sexual and Reproductive Health Clinical Guidance: Progestogen-only Injectable Contraception (December 2014, amended July 2023) https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-injectables-dec-2014/ • Faculty of Sexual and Reproductive Health Drug Interactions with Hormonal Contraception – May 2022 FSRH CEU Guidance: Drug Interactions with Hormonal Contraception (May 2022) | FSRH • Faculty of Sexual and Reproductive Health CEU Statement: Response to new study by Roland et al (2024). Use of progestogens and the risk of intracranial meningioma: national case-control study. FSRH response to study: Use of progestogens and the risk of intracranial meningioma (2024) | FSRH • College of Sexual and Reproductive Healthcare (2025) UK Medical Eligibility Criteria for Contraceptive Use. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) | CoSRH • Faculty of Sexual and Reproductive Healthcare Clinical Guideline: Quick Starting Contraception (April 2017) https://www.fsrh.org/Public/Documents/fsrh-clinical-guidance-quick-starting-contraception-april-2017.aspx • BPAS Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines. Updated November 2024 Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines • BPAS Safeguarding Adults at Risk policy. Updated July 2025 Safeguarding Adults at Risk

	• BPAS Safeguarding Children and Young People policy. Updated August 2025 Safeguarding Children and Young People • BPAS Medicines Management Policy. Updated May 2025. Medicines Management Policy • BPAS Record Keeping Policy. Updated December 2023. Record Keeping

Audit and ongoing monitoring of this PGD

Please refer to the 'Audit' section of the BPAS Patient Group Direction policy for additional guidance in relation to PGD audit. Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines

The PGD audit tool is available here: British Pregnancy Advisory Service - Audit Tools - All Documents (sharepoint.com).

Appendix A: Approved Practitioner List

Patient Group Direction (PGD) name:	Administration of intramuscular (IM) medroxyprogesterone acetate (DMPA) injection (150mg/1ml) v3.0	
	Valid from: 01/05/2026	**Expiry: 30/04/2029**

Registered health professional

By signing this PGD you are indicating that you agree to its contents and that you will work within it.

PGDs do not remove professional obligations or accountability. It is the responsibility of each professional to practise only within the bounds of their own competence and professional code of conduct. The practitioner MUST sign this document before they can work under this PGD.

I confirm that I have read and understood the contents of this PGD. I confirm that I am willing and competent to work to this PGD within my professional code of conduct.				
Name (print)	**Designation**	**Registration number**	**Signature**	**Date**

Authorising manager

I confirm that the registered health professionals named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of BPAS for the above named health care professionals who have signed the PGD to work under it.				
Name	**Position**	**BPAS Treatment Unit**	**Signature**	**Date:**

Note to authorising manager

- Score through unused rows in the list of registered health professionals to prevent additions post managerial authorisation.
- If registered health professional signatures need to be added at a later date, e.g. due to staffing changes, a separate Approved Practitioner List must be signed, ensuring the correct PGD name and version is detailed.
- This authorisation sheet should be retained to serve as a record of those registered health professionals authorised to work under this PGD for the period specified in the BPAS PGD policy.
- This list must be stored by the Treatment Unit in a designated folder and be available for immediate inspection, alongside any training / competency records. If a registered professional works across multiple sites, they must sign the Approved Practitioner List for each PGD at each BPAS site where they will use the PGD.