DOCTOR'S/NURSE PRACTITIONER'S CONSENT FOR ADMINISTRATION OF MEDICATION

To Whom It May Concern:

I authorize the certified caregivers from Vibrant Aging Community Center Home to assist with self-administration and/or administration for (patient name:_____)

_____on a daily basis.

Doctor/NP Full Name: _____

Doctor/NP Signature:_____

_____

Date:

Mailing address:

Vibrant Aging Community Center Ltd.
House No AE827
Windy Bay Ave
Winneba, Central Region, Ghana

Digital address:

CE-031-4100

Telephone:

+233 553913412