

**Catholic Charities**  
**Annual REVIEW Form for**  
**Authorization to Administer/Store Medication**

Name of Program: \_\_\_\_\_

Is the Program requesting a revision of procedures for authorizing to administer/store medication? (Please attach original authorization) \_\_\_YES \_\_\_NO, revision not requested.

If yes, please provide a brief description of proposed revision:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please summarize any identified risks or medication management concerns. If none indicate N/A. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prepared by: \_\_\_\_\_ Date \_\_\_\_\_

Request to revise:    Approved \_\_\_\_\_                      Not Approved \_\_\_\_\_

Request to continue: Approved \_\_\_\_\_                      Not Approved \_\_\_\_\_

Reason for denial with recommendation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of revision/review \_\_\_\_\_

Signature of CC Executive Director: \_\_\_\_\_