**USP <800> Designated Person(s) Responsibilities**

Effective \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_, [Company] has assigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Title) as the entity’s <USP> 800 Designated Person. By initialing and signing below, this Designated Person attests that they are trained in USP <800>, that they understand risks handing hazardous drugs may cause to themselves and others, the rationale and need for risk-prevention policies, and the risks of non-compliance that may compromise employee safety. The Designated Person attests that they accept responsibility for;

\_\_\_\_\_\_\_\_ developing and implementing appropriate USP <800> procedures;

 Initial

\_\_\_\_\_\_\_\_ overseeing entity compliance with USP <800> & other applicable laws, regulations, & standards;

 Initial

\_\_\_\_\_\_\_\_ ensuring USP <800> competency of personnel;

 Initial

\_\_\_\_\_\_\_\_ ensuring environmental control of the storage and compounding areas;

 Initial

\_\_\_\_\_\_\_\_ oversight of monitoring the USP <800> facility and maintaining reports of testing/sampling Initial performed in facilities and acting on the results, and;

\_\_\_\_\_\_\_\_ reporting potentially hazardous situations to the management team.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designated Person’s Signature  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Owner or Other Authorized Individual’s Signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designated Person’s Name (Print) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Owner or Other Authorized Individual’s Name (Print) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designated Person’s Title | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Owner or Other Authorized Individual’s Title |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |