

Form 4. Partnership Form To be completed by each member of the partnership.	NMDS-SC Ref No:
Your Organisation Name:	
Your Contact Name:	
Name of Partnerships/Lead Partner you are joining:	
Your NMDS-SC Registered Address:	
Telephone Number:	Post Code: Fax Number:
Email Address:	
Partner's Declaration: My organisation/business is a member of this partnership and we are happy for the Lead Organisation to sign the proposal on our behalf. <ul style="list-style-type: none"> • I understand that the Skills for Care funding is a contribution to the cost of individuals in my organisation achieving relevant adult units of competence. • I understand that I have a responsibility to inform the Lead Partner of adult units achieved and any relevant information that they need to maintain financial probity and a clear audit trail on funding spent. • I can, where appropriate, fund the same candidate using other funding. (I understand this has to be based on a shortfall in the funding and real cost and that no profit can be made from this contribution). • I am not funding individuals in this proposal with funding from other Skills for Care funding partnerships to which I might belong. • I understand that I am only able to claim for staff employed by this organisation. • I understand that I must keep a clear and robust audit trail of the funding received from Skills for Care. • I have completed the NMDS-SC organisation questionnaire. • I have updated my NMDS-SC organisational data. • I have encouraged and supported the completion of individual worker records. Name: (please print) _____ Position in Organisation _____ Signature: _____ Date: _____	