** Programme Application Form (PAF) 18/19: *Version 1***

**Non-Medical Prescribing (Independent and/or Supplementary)**

**Section One - all applicants to complete**

**Applicant name:**

**Employing organisation name:**

**Start date of employment in your current role:**

Please ensure you have completed and included the following sections:

[ ]  Section One – Declaration

[ ]  Section Two – Programme requirements

[ ]  Section Five – DMP confirmation (DMP handwritten signature required)

[ ]  Section Six – NMP lead / employer confirmation

Pharmacist applicants only, ensure the following is included:

[ ]  Section Three

[ ]  Written evidence relating to patient experience, area of practice and CPD

[ ]  Two examples of CPD from <http://uptodate.org.uk/home/welcome.shtml>

Nurse, Midwife and AHP applicants only:

[ ]  Section Four

**Declaration**

I confirm that the information contained within this application is accurate.

I understand that:

* I will not be accepted onto the course until I have applied online using this link <http://courses.uwe.ac.uk/Z51000077/non-medical-prescribing>. In order to apply you will need to register through the CPD portal by clicking on this link.
* I will not be accepted onto the course until the programme application form and any other required paperwork is uploaded to the CPD portal.
* I will not be automatically accepted onto the course if I do not have a diploma of Higher Education or above. If I do not have a Diploma of Higher Education or above, I confirm I have previously studied at level 3 (degree level or level 6) or above
* I will not be accepted onto the course until I have confirmed I have a valid Enhanced DBS certificate and the original has been seen by the CPD team by way of posting the original to the CPD team or confirming to the CPD team that you will bring it with you on the first day. We need to see the original certificate and cannot accept copies of your DBS certificate. Please see page 2 for further information.

|  |  |
| --- | --- |
| Signature of Student: (E-signature accepted)  | Date:  |

The following address can be used to return your DBS certificate:

Emily Haycock, University of the West of England, CPD Team, Room 2B16, Glenside Campus, Blackberry Hill, Bristol, BS16 1DD.

**Section Two - all applicants to complete**

**I confirm that I meet the following requirements for admission to the Non-Medical Prescribing (Independent and/or Supplementary) Programme as stated below:**

|  |
| --- |
| [ ]  I am a Registered Professional and intend to practice in an area where there is a need for me to prescribe as an Independent and/or Supplementary prescriber.Please tick as applicable:[ ]  Pharmacist [ ]  Nurse [ ]  Midwife [ ]  Physiotherapist [ ]  Podiatrist [ ]  Chiropodist [ ]  Therapeutic Radiographer [ ]  Radiographer (Supplementary Prescriber only) [ ]  Dietician (Supplementary Prescriber only)  |
| [ ]  I have a valid Enhanced DBS or, I am in the process of obtaining one.  *Additional information:* Should you have the original certificate and it is within 3 years of issue at the start of the course, please post in your original DBS certificate to the address on page 1 of this form. Or confirm to Emily Haycock in CPD that you will bring it with you on the first day of the course.  If older than 3 years at the start of the course, should you have registered with the update service, you can provide evidence of your DBS by way of checking the DBS database online for any updates. You can provide a screen print showing the issue date, certificate number and date checked online.  If you did not register for the online update service and your certificate is older than 3 years, you will be required to obtain a new enhanced DBS certificate which will have to be requested by your employers, and will include adult and child searches. You will not be accepted onto the course without a valid DBS. |
| [ ]  I have basic computer skills e.g. able to attach documents to e-mails, familiar with Word etc. |
| [ ]  I have a designated medical practitioner (DMP) in place  |
| [ ]  I have discussed with my mentor and my manager how the 12 directed learning days and the required number of supervised learning hours will be achieved (78 hours for Nurses and Midwives or 90 hours for Pharmacists and AHPs) |
| [ ]  I understand that there is a 100% attendance for the 12 face to face days. Unexpected absences will require discussion with the programme leader. |
| [ ]  I understand that the Non-Medical Prescribing programme is intensive and that there is an expectation that I will need to devote around 400 hours to studying |
| [ ]  I understand that although support is given to enhance my academic work, there is not capacity within the course timescales to be taught to write at Level 3 (6) or Level M (7)  |
|  Please indicate below if you have commenced a Prescribing Programme before: |
|  [ ]  No [ ]  Yes Location:  | Date:  | Results:  |

**Section Three – Pharmacist applicants to complete**

|  |  |
| --- | --- |
| Name (as stated on GPhC or PSNI register) |  |
| Number on GPhC or PSNI Register |  | [ ]  Checked by UWE  |

**Please provide written evidence detailing the following. You should use the space on page 4 for this and sign the declaration.**

1. That you have at least two years patient-orientated experience in a UK hospital, community or primary care setting following your pre-registration year (this needs to be verified by your employer/NMP lead or if you are self-employed, a reference who can corroborate the experience)
2. That you have an identified area of clinical practice in which to develop your prescribing skills, and have up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to your area of prescribing practice
3. That you have identified how you will gain regular access to patients within your area of clinical practice in order to achieve the required 90 hours supervised practice
4. That you are able to reflect on your own performance.

**Please upload two recent examples of continuing professional development (CPD) to the CPD portal.** Both examples should be related to your identified area of clinical practice; with one starting from the reflection stage. To do this please send in a print of your evidence from this website:

<http://uptodate.org.uk/home/welcome.shtml>

For pharmacists planning to train in an organisation in which they are not directly employed

1. That local governance requirements relating to access to patients and information records are met (for example through arrangement of an honorary contact)

**Section Three continued - Pharmacist applicants & NMP lead/employer/equivalent (for example General Practice Manager or lead GP partner)**

Use this space to provide written evidence to support Section Three. For self-employed applicants, you will need to provide a statement from a professional referee who can verify that you have at least two years patient-orientated experience.

|  |
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|  |

**I declare that the information provided in section three is accurate.**

I confirm that the above information has been read and I have verified it

|  |  |
| --- | --- |
| Signature of Pharmacist applicant (E-signature accepted):  | Date:  |

**Section Four – Nurse, Midwife and AHP applicants only to complete**

|  |  |
| --- | --- |
| Name (as shown on NMC or HCPC register) |  |
| NMC/HCPC Pin number |  |

|  |
| --- |
| Please give a brief indication of how the ability to prescribe medications Independently will transform practice and inform patient / client care (if you have been required to give this information on an application to your own organisation, you may wish to replicate that here) |

**I confirm that I have been qualified for at least 3 years, and that the year preceding the application to the course must be in the area that I intend to prescribe. Part-time workers must have practised for a sufficient period to be deemed competent by their employer.**

Now please the declaration below. (E-signature accepted)

|  |  |
| --- | --- |
| Signature of Nurse/Midwife/AHP applicant:  | Date:  |

**Section Five – For DMPs to complete**

**As the Designated Medical Practitioner I can confirm that:**

|  |
| --- |
| * I am registered with the GMC
 |
| * I am a Registrar, GP or above
 |
| * I am able to devote sufficient time to support the student in achieving supervised learning, either 78 hours for Nurses or 90 hours for Pharmacists and AHPs
 |
| * I have read and understood the role and responsibilities of the DMP as outlined in the ‘DMP Information email’
 |
| * I must be sufficiently impartial to the outcome for the student and, wherever possible, should not be the same person sponsoring the student to undertake the programme.
 |

Please supply the following information to ensure the Department of Health criteria is met for the supervision in practice for prescribers by medical assessors. Please tick the appropriate response.

**Department of Health (Nov 2001) Criteria:** Are you a registered medical practitioner who:

1. has had at least 3 years medical, treatment and prescribing responsibility for a group of patient/clients in the relevant field of practice?

Yes [ ]  No [ ]

**and** are you:

1. (a) within a GP practice and either vocationally trained or in possession of a certificate of equivalent experience from the Joint or Post-Graduate Training in General Practice?

Yes [ ]  No [ ]

OR (b) a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer?

Yes [ ]  No [ ]

**and** have you:

1. the support of the employing organisation or GP practice to act as the designated medical practitioner who will provide supervision, support and opportunities to develop competence in prescribing practice?

Yes [ ]  No [ ]

**and** have you:

1. some experience or training in teaching and/or supervision in practice?

Yes [ ]  No [ ]

If you are not an Approved Training Practice/Institution, then please outline your experience of teaching, supervision and assessment of students.

|  |
| --- |
|  |

Now please complete the DMP details on the next page.

**Designated Medical Practitioner**

|  |
| --- |
| Name (please print as shown on GMC register):  |
| Email address **(Please print):**  |
| Telephone number:  |
| Job Role:  |
| GMC number:  | [ ]  Checked by UWE |
| Signature: **(MUST BE HANDWRITTEN)**  | Date:  |

**Section Six – For NMP lead to complete**

**Employed Pharmacist applicants:**

**As the Non-Medical Prescribing Lead I can confirm that:**

|  |
| --- |
| * The applicant has at least two years patient-orientated experience in a UK hospital, community or primary care setting, following their pre-registration year
 |

**Employed Nurse, Midwife and AHP applicants:**

**The NMC requires employers to appraise applicant’s suitability to prescribe before they apply for a training place.**

**As the Non-Medical Prescribing Lead I can confirm that:**

|  |
| --- |
| * The applicant has been assessed as competent to take a case history, undertake a clinical assessment and diagnose
 |
| * The applicant has sufficient knowledge to apply prescribing principals taught on the course to their own field of practice
 |
| * The applicant must be able to demonstrate appropriate numeracy skills (which will be further developed and tested during the course)
 |
| * As far as you are aware the applicant has the ability to study at Level 3 or above (this will be checked by the CPD team)
 |
| * The applicant has discussed with their manager/DMP how the 78/90 hours supervised learning and the 12 directed learning days will take place
 |

**For all employed applicants:**

I confirm:

* 1. The applicant has discussed his/her participation on the Non-Medical Prescribing (Independent and/or Supplementary) programme with me.
	2. That there is clinical need within the applicant’s role to justify prescribing.
	3. That the organisation will support the applicant for the duration of the programme.
	4. Directed learning time is defined as a period of 12 days of focused learning to meet the defined content of this programme.
	5. That the applicant has a DBS which is less than three years old, or is in the process of obtaining one.

|  |  |
| --- | --- |
| Signature: (E-signature accepted)  | Date:  |
| Name:  |
| Organisation:  |
| Title/Position:  |
| Email address:  |
| Contact telephone number:  |