**APPLICATION FOR THE PRACTICE CERTIFICATE IN INDEPENDENT PRESCRIBING**

**(NON-MEDICAL PRESCRIBING)**

**Section 1**

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| If you have studied at the university before please provide your student ID number | | | | | | | | |  |  | |  |  | |  |  |  |
| **Self Employed Students will be required to undertake an interview (face-to-face or telephone) with the Course Team for the Practice Certificate in Independent Prescribing** | | | | | | | | | | | | | | | | | | |
| **Course Details** | | **Requested Start Date** | | **Please indicate which campus you wish to study at:**  **Coventry Campus 🞏 Scarborough Campus 🞏** | | | | | | | | | | | | | | |
| **Level of Study** | **6011CPD/6012CPD (Degree) 🞏** | | | | **7051SOH/7052SOH (Masters) 🞏** | | | | | | | | | | | | | |
| **Type of Prescriber** | Independent/Supplementary Prescriber (NMC V300)  Eligible professionals: Nurses, Midwives, Physiotherapist, Podiatrist | | | | Independent/Supplementary Prescriber (NMC V300)  Eligible professionals: Nurses, Midwives, Pharmacists, Physiotherapist, Podiatrist, Therapeutic Radiographer and Paramedics  Supplementary prescribing only: Diagnostic Radiographer and Dietician | | | | | | | | | | | | | |
| **Applicant Details** | | | | | | | | | | | | | | | | | | |
| **Applicants Name:** | | |  | | | | | | | | | | | | | | | |
| **Date of Birth: DD/MM/YYYY):** | | |  | **Title:** | |  | | | | | **Gender:** | | |  | | | | |
| **Profession:** | | | **Nurse/Midwife**  **🞏** | **Allied Health Professional**  Physiotherapist **🞏**  Podiatrist **🞏**  Dietician **🞏**  Therapeutic Radiographer **🞏**  Diagnostic Radiographer **🞏**  Paramedic **🞏** | | | | | | | **Pharmacist 🞏** | | | | | | | |
| **Job Title:** | | |  | | | | | | | | | | | | | | | |
| **Contact Details** | | | **Work** | | | | | **Home** | | | | | | | | | | |
| **Address:** | | |  | | | | |  | | | | | | | | | | |
| **Post Code:** | | |  | | | | |  | | | | | | | | | | |
| **Telephone No:** | | |  | | | | |  | | | | | | | | | | |
| **Mobile No:** | | |  | | | | |  | | | | | | | | | | |
| **Email Address:** | | |  | | | | |  | | | | | | | | | | |
| **Barring and Disclosure Check (previously CRB checks)** | | | | | | | | | | | | | | | | | | |
| **Do you have a current enhanced DBS (current employer and issued in last 3 years for nurses, and 3 months for AHPs)?** | | | | | | | **Yes 🞏 No 🞏** | | | | | | | | | | | |
| **If the answer to the above question is NO has an enhanced DBS been applied for?** | | | | | | | **Yes 🞏 No 🞏** | | | | | | | | | | | |
| **Date applied for:** | | | | | | |  | | | | | | | | | | | |
| **Pharmacists must provide evidence of a recent satisfactory DBS check** | | | | | | |  | | | | | | | | | | | |

**Section 2**

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| **Fee Status** | |
| **Country of Birth:** |  |
| **Nationality:** |  |
| **Country of domicile or area of permanent residence:** |  |
| **Date of first entry to the United Kingdom:** |  |
| **Who is expected to pay your fees? (Please Circle):** | Self-Funding / External Funding/ Charity / Sponsor |
| **External Funding/ Sponsor Charity/ Charity Name:** |  |
| **For Marketing Purposes Only: How did you hear about this course/ module? (Please Circle):** | Advertisement/ Colleague/ Family/  Workplace/ Previous Experience/ Other |

**Section 3**

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| --- | --- | --- | --- | --- | --- | --- |
| **Professional Eligibility (please complete section relevant to your professional background)** | | | | | | |
| **Employment History –please supply details of your employment history for the previous 5 years (current employer first)** | | | | | | |
| **Employer** | **Employers Address** | | **Role/Job Title** | | **Dates of Employment** | |
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|  |  | |  | |  | |
| **Nursing and Midwifery** | | |  | | | |
| **Are you a 1st level registered nurse/midwife/specialist community public health nurse currently on the NMC register?** | | | **Yes 🞏**  **No 🞏** | | | |
| **Do you have at least 1 years or equivalent relevant post registration experience?** | | | **Yes 🞏 (this will be checked against your employment history – see section 3)**  **No 🞏** | | | |
| **NMC PIN number** | |  | **Expiry Date** | | |  |
| **Allied Health Professionals** | | | | | | |
| **Professional Group** | | | |  | | |
| **Do you have at least 3 years or equivalent post qualification experience?** | | | | **Yes 🞏 (this will be checked against your employment history – see section 3)**  **No 🞏** | | |
| **HCPC Registration number** | |  | | **Expiry Date** | |  |

**Section 3 (cont’d)**

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| **Pharmacist** | | | | | | |
| **Do you have at least two years appropriate patient-orientated experience in a UK hospital, community or primary care setting following pre-registration year?** | | **Yes** 🞏 **(this will be checked against your employment history – see section 3)**  **No** 🞏 | | | | |
| **Have identified an area of clinical practice in which to develop their prescribing skills and have up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to their intended area of prescribing practice?** | | **Yes** 🞏 **(please supply supporting information in section 5 of this form)**  **No** 🞏 | | | | |
| **Can you demonstrate how you currently reflect on your own performance and take responsibility for your own CPD?** | | **Yes** 🞏 (**Please supply further information in the supporting information section of this form)**  **No** 🞏 | | | | |
| **GPhC Registration number** |  | **Expiry Date** | | |  | |
| **Pharmaceutical Society of Northern Ireland (PSNI) number** |  | **Expiry Date** | | |  | |
| **For Students on an HEE pathway**  **Educational Supervisor**  **E-mail contact:**  **Tel:** | **Signature:** | **Print Name:** | | | **Date:** | |
| **If HEE funded please identify the pathway you are undertaking** | **Clinically Enhanced Independent and supplementary prescribing** | |  | **Independent and supplementary prescribing** | |  |

**Section 4**

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| **Professional Qualifications attained (since registration)** | | | | | |
| **Awarding Body** | **Level** | **Year** | **Subject** | **Result** | **Place of study** |
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| **Supporting Information/Statement (additional qualifications, professional experience likely to facilitate prescribing).**  **For nurses this must include evidence of the ability to study at degree level.**  **For Paramedics this must include evidence to demonstrate working at an advanced level of practice**  **For Pharmacists this can be evidence of 2 of their GPhC CPD portfolio entries**  **You can supply a supporting professional reference, academic/CPD certificates and a CV where available** | | | | | |
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**Section 4 (cont’d)**

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| **Have you registered or commenced and partially completed an independent prescribing course previously?**  If students have previously applied for, and/or commenced a course previously the reason for non-completion/non-acceptance MUST be identified. Applications are considered against the standard course entry requirements for that year of entry. Any new application should demonstrate how the application has improved. For students who have previously failed a prescribing course, the application must demonstrate what action the student has taken to remedy the element/s which they failed. All students who have previously failed a prescribing course will be invited to interview and the university will draw on information from previous applications or any previous registrations at the University to assess suitability for the prescribing course. | **\*Yes🞏**  **No 🞏** |
| **\*If yes please give reasons for NOT completing the course** | |

**Section 5**

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| **Independent/Supplementary prescribers. Complete the following Section** | | | |
| **Have you completed a health/clinical assessment course (or specialist equivalent) (not applicable to pharmacists)** | | **Yes 🞏**  **No 🞏** | |
| If NO have you been deemed competent by an appropriate Professional Colleague, in clinical assessment and diagnosis prior to being put forward for this course (see professional regulations for guidance re competence). The University retains the right to require the student to undertake an OSCE at interview - For candidates who fail to demonstrate competence during the OSCE, advice is provided regarding accessing suitable courses.  Please give details and ensure section below is completed and signed  **I confirm that the applicant is competent in clinical assessment and diagnosis and is a suitable candidate for non-medical prescribing**  (NB this may be achieved by internal assessment of competence or completion of an appropriate  health/clinical assessment course) | | | |
| **Name (Print)** |  | **Title/position** |  |
| **Signature** |  | **Qualification** |  |

**Section 6**

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| **Practice Supervision/Assessment Arrangements** | | | | | | | |
| **Allied Health Professionals and (until November 2019) pharmacists are required to identify a Designated Medical Practitioner prior to starting the course**  **The designated medical practitioner is the person who will certify that successful pharmacists are competent to practice as independent prescribers.** | | | | | | | |
| **Eligibility criteria for becoming a Designated Medical Practitioner (DMP)** | | | | | | | |
| **Are you a registered medical practitioner who:** | | | | | | | |
| 1. Has normally had at least 3 years recent clinical experience for a group of patients/clients in the relevant field of practice | | | | | **Yes 🞏**  **No 🞏** | | |
| **and are you:**  **ii) A)** within a GP practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the Joint Committee for Post-Graduate Training in General Practice Certificate (JCPTGP**)**  **OR**  **B)** is a specialist registrar, clinical assistant or Consultant within a NHS Trust or other employer | | | | | **Yes 🞏**  **No 🞏**  **Yes 🞏**  **No 🞏** | | |
| **and have you:**  **iii)** Support of the employing organisation or GP practice to act as DMP who will provide supervision, support and opportunities to develop competence in prescribing practice | | | | | **Yes 🞏**  **No 🞏** | | |
| **and have you:**  **iv)** some experience or training in teaching and or supervising in practice  **If not an Approved Training Practice/Institution , then please outline your experience of teaching, supervision and assessment of students** | | | | | **Yes 🞏**  **No 🞏** | | |
| **Agreement by Designated Medical Practitioner for Supervision of Applicant** | | | | | | | |
| **Please tick** | **GP🞏** | **Consultant 🞏** | **Specialist Registrar 🞏** | **Clinical Assistant 🞏** | | | **Other 🞏** | |
| **Speciality:** |  | | | **GMC registration**  **Number:** | |  | | |
| **Name of Medical Practitioner:**  **(Please print)** | |  | | **Signature:** | | | | |
| **Work Address:**  **Telephone Number:** | |  | | | | | | |
| **E-mail Address** | |  | | | | | | |

**Section 6 (Cont’d)**

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| **This section only applies from November 2019**  **Pharmacists are required to identify a Designated Prescribing Practitioner prior to starting the course**  **The designated prescribing practitioner is the person who will certify that successful pharmacists are competent to practice as independent prescribers.** | | | | | | |
| **Eligibility criteria for becoming a Designated Prescribing Practitioner (DPP)** | | | | | | |
| **Are you a registered healthcare practitioner Great Britain or Northern Ireland with legal independent prescribing rights, who is suitably experienced and qualified to carry the supervisory role, and who has demonstrated CPD or revalidation relevant to this role.** | | | | | **Yes** | **🞏** |
| **No** | **🞏** |
| **AND have you** **support of the employing organisation to act as DPP who will provide supervision, support and opportunities to develop competence in prescribing practice** | | | | | **Yes** | **🞏** |
| **No** | **🞏** |
| **Agreement by Designated Prescribing Practitioner for Supervision of Applicant** | | | | | | |
| **Please indicate your profession** | **Nurse**  **🞏** | **Pharmacist 🞏** | **GP/Consultant/Registrar**  **🞏** | | **Physiotherapist**  **🞏** | |
| **Speciality:** |  | | **Professional Body registration number** |  | | |
| **Name of Prescribing Practitioner:**  **(Please print):** |  | | **Signature** | | | |

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| --- | --- |
| **Work Address:**  **Telephone Number:** |  |
| **E-mail Address:** |  |

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| **Nurses are required to identify a Practice Assessor (PA) and Practice Supervisor (PS) for the duration of the NMP course. The PA and PS must be registered healthcare professionals and experienced prescribers with suitable qualifications for the course the student is undertaking.**  *The Practice Assessor (PA) and Practice Supervisor (PS) must be fit to undertake that role and must have appropriate training and experience.*  *IN addition, prospective PA and PS must have:*  *The Practice Assessor (PA): a registered healthcare professional and an experienced prescriber with suitable equivalent qualifications for the course the student is undertaking.*  ***The role of your PA is to assess your competence in practice.***  *The Practice Supervisor (PS):*   * *active prescribing competence applicable to the areas in which they will be supervising;* * *appropriate patient-facing clinical and diagnostic skills;* * *supported or supervised other healthcare professionals, and* * *The ability to assess patient-facing clinical and diagnostic skills.* |

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| **Agreement by Practice Assessor** | | | | | |
| **Please indicate your profession:** | **Nurse**  **🞏** | **Pharmacist**  **🞏** | **GP/Consultant/Registrar**  **🞏** | | **Physiotherapist**  **🞏** |
| **Speciality:** |  | | **Professional Body registration number:** |  | |
| **Name of Prescribing Practitioner:**  **(Please print):** |  | | **Signature:** | | |
| **Work Address:**  **Telephone Number:** |  | | | | |
| **E-mail Address:** |  | | | | |

**Section 6 (Cont’d)**

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| **Agreement by Practice Supervisor** | | | | | |
|  | | | | | |
| **Please indicate your profession:** | **Nurse**  **🞏** | **Pharmacist**  **🞏** | **GP/Consultant/Registrar**  **🞏** | | **Physiotherapist**  **🞏** |
| **Speciality:** |  | | **Professional Body registration number:** |  | |
| **Name of Prescribing Practitioner**  **(Please print):** |  | | **Signature:** | | |
| **Work Address:**  **Telephone Number:** |  | | | | |
| **E-mail Address:** |  | | | | |

**Section 7**

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| **Employer Approval - Line Manager Confirmation (Not applicable to self-employed students)** | | | | |
| **Please confirm the following:** | | | |  |
| 1. **Agreement for the applicant to be released for a minimum of:**   **26 taught study days with an additional 12 x 7.5h days (90 hours) supervised learning in practice**     1. **The applicant has appropriate supervision in practice relevant to their profession and practice.** 2. **The area of non-medical prescribing activity is linked to core service provision.**   *If the service is time limited or a pilot/service please give details below;*   1. **On qualification the applicant will have access to a prescribing budget and other practical requirements for prescribing.** 2. **On qualification the on-going CPD requirements of the prescriber will be supported.** 3. **I confirm that independent prescribing is included in the applicants Job description (JD) or a letter of empowerment to prescribe within the Trust will be appended to the JD.** | | | | **Yes 🞏 No 🞏**  **Yes 🞏 No 🞏**  **Yes 🞏 No 🞏**  **Yes 🞏 No 🞏**  **Yes 🞏 No 🞏**  **Yes 🞏 No🞏** |
| **Name (Please print):** |  | | | |
| **Job Title:** |  | | | |
| **Work Address:** |  | | | |
| **Telephone Number:** |  | | | |
| **E-mail Address:** |  | | | |
| **Signature:** |  | **Date:** |  | |

**Section 8**

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| **Trust Approval- Agreement by the Prescribing lead (not applicable to self-employed students)** | |
| **Prescribing lead agreement that there will be access to a prescribing budget and a benefit to patient services by training this nominee** | |
| **Name (Please print):** |  |
| **Organisation:** |  |
| **Job Title:** |  |
| **Work Address:** |  |
| **Telephone Number:** |  |
| **Email address:** |  |
| **Signature:** |  |

**Section 9**

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| **Funding** | | | | | | | |
| **NOTES:**  **If you are funded by the NHS LBR commissioned Contract you MUST obtain the signature of your Line Manager and the Trust Educational Lead prior to submission.** | | | | | | | |
| I hereby agree, on behalf of the Company or Authority, to pay all fees applicable to the course, in respect of the student named, on receipt of an invoice from Finance at Coventry University. The amount payable will be in accordance with the fees agreed by the University’s Governors for the course attended. | | | | | | | |
| Line Manager Signature: | Name in Capitals: | | | | | | Date: |
| Educational Lead Signature: | | | | | | | |
| Name in Capitals: | | | | | Date: | | |
| **Fee Authorisation – External Funder (e.g. Employer) / Other**  **For completion by person authorising funding.**  **NOTES:**   1. If your organisation requires an invoice for payment of fees complete this section. 2. If a charitable organisation, training agency, industry etc requires an invoice in payment of fees complete this section.   **If you are funded by more than one employer/organisation then please copy this section and get it completed for each organisation authorising funding.** | | | | | | | |
| Student’s surname: | | Forename(s): | | | | | |
| Amount payable by External Funder £ | | Amount payable by student £ | | | | | |
| Course: | | | | | | | |
| **Invoice to be sent to:** | | | | | | | |
| External Funder name: | | | | | | | |
| For the attention of: | | | Purchase order no: | | | | |
| Reference/contact name: | | | | | | | |
| Address: | | | | | | | |
|  | | | | | | Postcode: | |
| Telephone no: | | | | Mobile no: | | | |
| E-mail: | | | | Fax no: | | | |
| I hereby agree, on behalf of the Company or Authority, to pay all fees applicable to the course, in respect of the student named, on receipt of an invoice from Finance at Coventry University. The amount payable will be in accordance with the fees agreed by the University’s Governors for the course attended. | | | | | | | |
| Authorising Signature: | | | | | Position: | | |
| Name: | | | | | Date: | | |
| **NOTE: Students who withdraw from a part-time course will not be entitled to a refund of the whole or any proportion of the tuition fee**. | | | | | | | |

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| **Declaration (Student) Agreement** | | |
| I confirm that, to the best of my knowledge, the information given in this form is correct and complete. I have read the Notes for Guidance, in particular those relating to this section. I understand these instructions and I agree to abide by the conditions set out there.  **PLEASE NOTE THAT IN ACCORDANCE WITH OUR PRIVACY NOTICE FOR STUDENT APPLICANTS AND PRIVACY NOTICE FOR STUDENTS, IF YOU ARE FUNDED BY AN EMPLOYER/SPONSOR, SOME INFORMATION CONTAINED IN THIS FORM MAY BE MADE AVAILABLE TO THEM, AND INFORMATION REGARDING YOUR ATTENDANCE, DISCIPLINARY, ACADEMIC CONDUCT PROCEDURES AND RESULTS WILL ALSO BE MADE AVAILABLE TO THEM. YOUR SIGNATURE BELOW DEMONSTRATES YOUR AGREEMENT TO THIS PROCESS.** | | |
| **Signature** |  | **Date** |
| **Print Name** |  |

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| **Please return this form to:** |

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| --- | --- |
| CPD Admissions - HLS, Faculty of Health & Life Sciences, Richard Crossman Building, Priory Street, Coventry, CV1 5FB. | |
| Telephone number: 024 7765 7142/5989/5158 | Email to: [cpdadmissions.hls@coventry.ac.uk](mailto:cpdadmissions.hls@coventry.ac.uk) |

**Please note after submitting your application form to** [**cpdadmissions.hls@coventry.ac.uk**](mailto:cpdadmissions.hls@coventry.ac.uk) **you will receive an automated email response acknowledging receipt.**