**APPLICATION FOR THE CONVERSION COURSE FROM SUPPLEMENTARY TO INDEPENDENT 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**  |
| **Course Details** | **Requested Start Date** | **Please indicate which campus you wish to study at:****Coventry Campus 🞏 Scarborough Campus 🞏**  |
| **Level of Study** | **6013 CPD Non-accredited** Conversion Course from supplementary to independent prescribing |
| **Type of Prescriber** | Eligible Professionals:Physiotherapists, Podiatrists, Therapeutic Radiographers |
| **Applicant Details** |
| **Applicants Name:** |  |
| **Date of Birth (DD/MM/YYYY):**  |  | **Title:** |  | **Gender:** |  |
| **Profession:** | Physiotherapist **🞏** | Podiatrist **🞏** | Therapeutic Radiographer **🞏** |
| **HCPC Registration number:** |  | **Expiry Date:** |  |
| **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 months for AHPs)?** | **Yes** | **🞏** | **No** | **🞏** |
|  |
| **If the answer to the above question is NO has an enhanced DBS been applied for?** | **Yes** | **🞏** | **No** | **🞏** |
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| **Date applied for:**  |  |

**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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**Section 4**

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| **Practice Supervision/Assessment Arrangements** |
| **Allied Health Professionals 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 5**

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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 No:** |  |
| **E-mail Address:** |  |
| **Signature** |  | **Date:** |

**Section 6**

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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 No:** |  |
| **Email Address:** |  |
| **Signature** |  |

**Section 7**

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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: |

**Section 7 (cont’d)**

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| 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 IF YOU ARE FUNDED BY AN EMPLOYER/SPONSOR INFORMATION CONTAINED IN THIS FORM AND INFORMATION REGARDING 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 7142/5989/5958/5388 | Email to: cpdadmissions.hls@coventry.ac.uk |

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