Application form for NMC registrants for 2019/20 entry to Non-Medical Independent and Supplementary Prescribing Course (v300)

Please select level of study that this application relates to:-

Level 6 (Honours) [ ] Level 7 (Masters) [ ]

Please indicate your profession

Nurse [ ] Midwife [ ]

Your full name ........................................................................................................................................

Professional registration number ............................................. Expiry date ......................

Academic Pathway: Stand-alone non-medical prescribing course [ ]
MSC Advanced Practice [ ] Other- please state .................................................................

Preferred intake*: September 2019 [ ] January 2020 [ ]

*We will try our best to accommodate your request however applications are dealt with on a first come first served basis and as such we are unable to guarantee entry on your requested cohort.

All applicants must declare if they have ever enrolled on a non-medical prescribing course before. Please ring: YES / NO If yes please give details in Section 1(h)

The course team will process your application and inform you of the outcome.

Once approved you will then need to enroll for UOS. You cannot complete your enrollment at UOS until your prescribing application has been approved

If further information is required or you do not appear to meet the selection criteria a member of the team will be available to discuss next steps with you.
For office use:

Date application received ..........................................................

Applicant Professional registration check:

Date checked ..........................................................

Expiry date ..........................................................

Signed ..............................................................................

DMP Registration check with General Medical Council (GMC)

Date Checked..........................................................

Expiry date..........................................................

Signed..............................................................................

Application approved by academic team  YES □  PENDING □  NO □

Comments..........................................................................................................................

..........................................................................................................................

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Signed ..........................................................  .......  Date..........................................................
### 1. APPLICANT DETAILS

**a. Full name (PRINT)**

- …………………………………………………………………………………………………..  DOB  ……./……../………....

**Home address:** …………………………………………………………………………………………………….
- ………………………………………………………………………………………………………………………………………..

**Contact details**

- Telephone: Work……………………………….. Personal  …………………………………………………..

**Preferred E-mail:**

**b. Job title**

- ………………………………………………………………………………………………………………..Grade...

**Clinical speciality/Prescribing setting:** state below: i.e. GP practice, prison, A&E, community care, walk in centre, diabetes centre, outpatients/in-patients, hospital department/wards, community pharmacy, medical aesthetics. **If you will be prescribing for 2 areas please give details of both.**

**c. Professional Regulator requirements of NMC**

**NMC** registrants must have 3 years post qualification experience prior to undertaking the prescribing course. The year immediately prior to undertaking the prescribing course must be in the field in which they intend to prescribe.

**Time in current role** …………………………………………………………………………………………………

**Professional Registration**

- PIN…………………………………… Expiry date ……………….. Date of first registration ……………

**d. DBS requirements**

All applicants must have an up to date DBS before starting the course (must be within 3 years) **This is a professional regulatory requirement.**

- **Date of last DBS check**……………………………….. State if pending: …………………………………

**e. Employer details**

**Name and address of employing organisation**
- ……………………………………………………………………………………………………………………..

**Type of employment:** NHS/ PRIVATE / SELF

**OTHER please state:**………………………………………………………………………………………………
f. Please identify DRUGS you are most likely to prescribe

g. Please provide detail of the rationale for your application. Outline for example the service change that you will be providing, how regular will you be prescribing, the benefits to the patient/ service delivery.

h. Complete this part only if you have applied and/or commenced a prescribing course at another HEI (Higher Education Institution)
   Please detail HEI and identify reasons for not completing:

2. EDUCATION and QUALIFICATIONS

a. Please list all your professional registered or recordable qualifications and dates attained:

<table>
<thead>
<tr>
<th>Professional qualifications</th>
<th>Academic Level Certificate/ Diploma/ Degree</th>
<th>Date</th>
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<td>i.e. -Registered nurse/Midwife/v100 prescriber/teacher etc</td>
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b. Please list on the next table details of post registration study
   List all post registration CREDITED continuing professional development (CPD) (modules etc) undertaken at any time and NON- accredited study/CPD undertaken in the last 3 years only

Evidence of ability to study at undergraduate degree level (level 6/bachelors) is an entry requirement for all candidates and must be provided. Advanced Paramedics should normally hold an undergraduate degree so they are ready for postgraduate master's level study (level 7).

-If you have achieved a full bachelor's degree/masters just list the award not individual modules in it.
-If you are currently undertaking a degree/masters please give name of programme and list all single modules completed so far.
-If you have undertaken stand-alone modules only then list all these

If you have not studied at degree level then you will need to access alternative study at level 6 (degree) prior to applying for the prescribing programme.
<table>
<thead>
<tr>
<th>Title of Award / module/ course /study day</th>
<th>Academic Level</th>
<th>Credits awarded</th>
<th>Academic Institution or Provider</th>
<th>Date</th>
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*Continue the above as required:*

**All candidates: Please identify your education/training and/or experience in clinical assessment and diagnosis.**

*(It is an NMC requirement that nurses possess skills in clinical assessment and diagnosis relevant to the area of future prescribing practice prior to undertaking this course).*
**SECTION 2: To be completed by the CLINICAL LEAD/LINE MANAGER**

Please confirm/comment on:

- **a.** The competency of the applicant to take a history, undertake a clinical assessment, and **diagnose** in their field of practice

- **b.** The **numeracy** skills of the applicant (To be further developed within the context of prescribing and assessed on the course)

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**NB-** Employers should not put NURSE candidates forward if they have not demonstrated the ability to: diagnose in their area of speciality and undertake basic numeracy skills. It should be possible to identify whether a registrant has these skills through CPD/appraisal reviews within the work place setting.

- **c.** The **clinical need** within the registrant's role to justify prescribing on qualification:

- **d.** The **clinical knowledge** base of the applicant in their own area and field of practice:

- **e.** Is prescribing identified as a **service need** and in the applicants Personal Development plan?

- **f.** What evidence is there that the applicant **undertakes CPD**?

- **g.** Are arrangements in place for the **78 hours supervised practice by a Designated Medical Practitioner (Doctor)**?

- **h.** The **clinical governance mechanisms** in place within the organisation to support the prescriber on completion:

- **i.** Can the applicants prescribing be **financially supported through budgetary mechanisms on successful completion**?

Your Name .................................................................Job Title .................................................................

Organisation and Address ............................................................................................................................

Contact Tel No: .............................................................E-mail: ....................................................................

In signing you agree to support the applicant for this course of study; releasing them for the 26 campus based days and ensuring provision of 78 hours supervision/assessment in practice

Signature: ............................................................................ Date: ..................................................

SECTION 3: To be completed by the PROFESSIONAL LEAD responsible for NON-MEDICAL PRESCRIBING within the Trust/CCG/Organisation

Please tick against the following to confirm or NA if not appropriate to your circumstances:

A service has been identified where Independent/supplementary prescribing will benefit the patient and the NHS in terms of quicker and more efficient access to medicines for patients

The relevant clinical lead(s) have agreed to support the introduction of Independent/supplementary prescribing for this group of patients

Arrangements have been made that allow the applicant to be released for training

The applicant will be in a position to prescribe on completion of training

The applicant will have access to a budget to meet the costs of their prescriptions on completion of training

Name..........................................................................................................................................

Job title........................................................................................................................................

Organisation and address..........................................................................................................

..................................................................................................................................................

Contact Telephone No.................................................E-mail:....................................................

I agree to support the applicant for this course of study.

Signature:.................................................................................Date:..................................................
SECTION 4: (To be completed by the Designated Medical Practitioner (DMP))

Name……………………………………………………………………………………………………
Qualifications: ........................................................................................................................
...................................................................................................................................................
GMC number………………………………………Expiry date...........................
Clinical area:..........................................................................................................................
Work Address........................................................................................................................
Tel No:…………………………………......E-mail:............................................................

Please supply the following information in line with Department of Health criteria for the supervision in practice of the trainee independent/supplementary prescriber (DH Nov 2005)

Are you a registered medical practitioner who: 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

Are you:
(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 an NHS Trust or other NHS Provider? Yes No

or (c) other employed, (i.e. private) please give details:

Have you: the support of the employing organisation /GP practice to act as the DMP to provide supervision, assessment, support and opportunities to develop the students' competence in prescribing practice? Yes No

Have you: current/recent experience in training in teaching and/or supervision in practice? Yes No

Are you in an Approved Training Practice/Institution? Yes No

Briefly outline your experience of teaching, supervision and assessment of students
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..................................................................................................................................................
..................................................................................................................................................

I confirm that I have agreed to supervise the applicant in their developing prescribing role for a period of learning in practice of 78/90 hours during the course duration. (Nurses 78, AHPs 90

Signature:.................................................................Date:.................................................

NB: A DMP handbook, which outlines the key DMP responsibilities, has been sent out to the applicant with this application form for your attention.
SECTION 5: Self-employed registrants ONLY
Complete if you are self-employed for any part of your future prescribing role

Self-employed role details
...................................................................................................................................................
...................................................................................................................................................

Please outline the clinical governance that will be in place for you to support your prescribing on completion of the prescribing course.

Please confirm how your prescribing be will be financially supported (i.e. costs of prescriptions) through relevant budgetary mechanisms on successful completion.

Please provide evidence to demonstrate: (You may wish to attach this as an appendix)

1. Your competency to take a history, undertake a clinical assessment, and diagnose in your field of practice
2. Your numeracy skills
3. The clinical /service need within your role to justify prescribing on qualification
4. The clinical knowledge base and experience you have in the area in which you will be prescribing

SECTION 6: Application check list
Must be completed by the APPLICANT prior to submitting form

<table>
<thead>
<tr>
<th>*delete as appropriate / Mark NA as appropriate</th>
<th>Tick to confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I am working within a service where *independent and/or *supplementary prescribing will benefit the patient in terms of quicker and more efficient access to medicines.</td>
<td></td>
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<tr>
<td>• My line/clinical manager has completed the Section 2 in support of application</td>
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<tr>
<td>• I am registered with the NMC and have at least 3 years’ post-registration experience as a Nurse or Midwife</td>
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<tr>
<td>• A Designated Medical Practitioner has completed section 4</td>
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<tr>
<td>• The NMP lead in the NHS Trust/supporting organisation has completed Section 3</td>
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<tr>
<td>• I am in a position to prescribe on completion of training</td>
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<tr>
<td>• Funding in principle has been organised</td>
<td></td>
</tr>
<tr>
<td>• Arrangements have been made that allow me to be released for training</td>
<td></td>
</tr>
<tr>
<td>• DBS is up to date/pending</td>
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</tr>
</tbody>
</table>
SECTION 7: Funding

To be completed by the applicant:

PleaseTick the confirmed funding route*:

☐ LBR funded (HEE) ☐ Sponsored

☐ Self-Funding

*It is the applicant’s responsibility to ensure that the correct information is provided.

I authorise University of Suffolk staff members to use my personal details given on this form to raise a funding voucher on my behalf once my application has been approved by the course team.

Approve ☐ Decline ☐

To be completed by Trust/Employer Representative:

I confirm that the above funding has been agreed for the applicant.

PLEASE PRINT

Name…………………………………………………………………………………..

Job title………………………………………………………………………………..

Signature:……………………………………….. Date:……………………………..
Completed forms:

Once all Sections have been completed please return all pages of this form by email to cpdprovision@uos.ac.uk or post to:

Sharon Versey (Course Administrator)
University of Suffolk
Waterfront Building, W102
Neptune Quay
Ipswich
IP4 1QJ

Incomplete application forms cannot be processed and so will impede your application

Thank you.

Your application will be processed by the course team and you will be informed of the outcome.

If further information is required or if you do not appear to meet the selection criteria you will be contacted by a member of the team.

NB-please note you cannot enroll at UOS until your prescribing course application and funding have been approved