

APPLICATION FORM (do not alter this form in any way)

INDEPENDENT AND SUPPLEMENTARY PRESCRIBER EDUCATION

This form should be completed and submitted in addition to the Learning Beyond Registration Module application form

When completed please check that:

- 1. ALL sections have been fully completed on BOTH forms**
- 2. Organisational Statement has been signed - Part 1 on this form**
- 3. Agreement with Supervisor/Designated Medical Practitioner has been signed – Part 2 on this form**
- 4. Candidates agreement has been signed – Part 3 on this form**

Please note unless all details and documentation are completed the application will be returned to you thereby delaying your registration and may result in a lost place.

PART 1: ORGANISATIONAL STATEMENT - NB AUTHORISED SIGNATURE ONLY WILL BE RECOGNISED

- I agree to release the applicant to attend the Independent and Supplementary Prescribing programme and to allow them protected learning time to develop their skills and competencies as an independent/supplementary prescriber. This includes eight face-to-face university taught days and 10 further days of protected learning time*.
- I agree to support and enable the applicant to utilise Independent and/or Supplementary Prescriptive authority on successful completion of the programme.

* NB: Protected learning time is defined as a period learning to meet the defined content of this programme, where the applicant must not be counted in their employers' staffing numbers. This learning may take place in either practice or academic settings, as appropriate to the content of learning (NMC 2006)

I confirm that _____ meets the following
Applicant's Name

requirements for entry onto the Independent & Supplementary Prescribing Programmes set by the NMC & HCPC and that:

Please tick each box to indicate compliance

ALL APPLICANTS

1. They are an employee with a minimum of three years post-registration clinical experience (or part-time equivalent), of which at least one year immediately preceding their application to the training programme should be in the clinical area in which they intend to prescribe, and that they have current registration with either the NMC or HCPC	
2. They have relevant numeracy skills.	
3. Occupational health clearance has been conducted satisfactorily with an acceptable outcome (and completed within the last four months for a non-NHS employee).	
4. A medical prescriber has agreed to contribute to and supervise 12 days of learning in practice.	
5. They will have appropriate supervised practice in the clinical area in which they will be expected to prescribe.	
6. Assessment will be undertaken in such an environment according to the requirements of the University of Southampton Faculty Of Health Sciences.	
7. Their post is one in which they will have the need and the opportunity to act as an independent and or supplementary prescriber immediately upon qualifying;	
8. There is a local need for them to prescribe (NHS Trusts and Organisations will decide whether there is a local need for staff to access prescribing training, Practitioners should not be able to undertake NHS funded training unless there has been prior agreement about the therapeutic area in which they will prescribe).	
9. On successful completion they will have access to the prescribing budget to meet the costs of their prescriptions	
10. They will have access to CPD opportunities on completion of the course;	
11. They will work within a robust clinical governance framework.	

NURSES ONLY

They are assessed as being competent to take a history, undertake a clinical assessment/examination and make a diagnosis (i.e. within their area of practice they must be able to carry out a comprehensive assessment of the patient's physiological and/or mental health condition, understand the underlying pathology and the appropriate medicines regimen that make a proficient and competent prescriber).

AHPs ONLY

1. They are working at an advanced practitioner or equivalent level and have demonstrated the ability to reflect on their own performance and take responsibility of their own continuing professional development (CPD), including development of networks for support ,reflection and learning
2. A DBS check must have been completed within the last 3 months

NURSES AND MIDWIVES ONLY

A DBS check has been obtained within the last 3 years for all NHS staff

NURSES AND MIDWIVES ONLY

A DBS screening has been satisfactory and completed within the last four months for a non-NHS employee.

Authorised Signature: _____

Name in Block Capitals: _____

PART 2 – INDEPENDENT/SUPPLEMENTARY PRESCRIBER DESIGNATED MEDICAL PRESCRIBER AGREEMENT

Name of Supervising / Designated Medical Practitioner (DMP) _____

Qualification _____

Address _____

Contact Telephone Number _____ email _____

Please supply the following information to confirm that you meet the Department of Health criteria (DH 2007) for the supervision in practice of student non medical prescribers.

Please tick in the appropriate boxes

Are you a registered medical practitioner who:

(i) 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

(ii) (a) is 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? **or** Yes No

(b) is a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer? Yes No

and

(iii) has the support of the employing organisation or GP practice to act as the DMP who will provide supervision, support and opportunities to develop competence in prescribing practice? Yes No

and

(iv) has some experience or training in teaching and/or supervision in practice? Yes No

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

and

(v) normally works with the student prescriber. If this is not possible (such as in nurse-led services or community pharmacy), arrangements can be agreed for another doctor to take on the role of the DMP, provided the above criteria are met and the learning in practice relates to the clinical area in which the trainee prescriber will ultimately be carrying out their prescribing role. Yes No

I confirm that I have agreed to facilitate, a total of twelve practice days training opportunities, supervision, support and participate in assessment for (student name) _____ to enable them to undertake the Independent and/or Supplementary Prescribing course.

Signature: _____ Date: _____

PART 3 – STATEMENT OF COMMITMENT TO UNDERTAKE THE PREPARATION FOR THE INDEPENDENT AND/OR SUPPLEMENTARY PRESCRIBERS COURSE;

Please write a short paragraph on aspects of independent and/or supplementary prescribing pertinent to your current practice, *use a continuation sheet if necessary*. This will form the introduction to your portfolio;

Describe the field of clinical practice you are currently involved in (no more than 100 words)?

How do you envisage that independent and/or supplementary prescribing will develop your practice? (No more than 100 words)?

What area or specific groups of drugs do you envisage you will prescribe in your clinical practice? (No more than 100 words)?

What academic study have you previously completed (please provide academic level e.g. 6 or 7)?

PART 4 - TO BE COMPLETED BY APPLICANT

DECLARATION BY APPLICANT

I confirm that the information on this form is correct to the best of my knowledge, and I consent to the University. I confirm that I have read and understood all course requirements and have met stated pre-requisites. I agree to undertake a police screening check (where appropriate) and provide evidence when requested and to meet all cost implications.

I have not previously undertaken an Independent/Supplementary Prescribing Programme

Applicant signature: _____ **Date:** _____

If you have previously commenced or completed aspects of an Independent or Supplementary Prescribing Programme you are advised to contact the Programme lead to discuss whether it is appropriate for you to reapply.

UNLESS ALL DETAILS ARE COMPLETED THIS FORM WILL BE RETURNED TO YOU THEREBY DELAYING YOUR REGISTRATION AND MAY RESULT IN A LOST PLACE

THIS FORM, TOGETHER WITH THE COMPLETED UNIT APPLICATION FORM SHOULD BE RETURNED TO THE, STUDENT OFFICE, FACULTY OF HEALTH SCIENCES, BUILDING 67, UNIVERSITY OF SOUTHAMPTON, HIGHFIELD, SOUTHAMPTON, SO17 1BJ