## Image result for de montfort university

## APPLICATION FORM FOR PRACTICE CERTIFICATE IN INDEPENDENT PRESCRIBING (CONVERSION COURSE) FOR PHARMACISTS

**Instructions and Information**

This form must be completed by the applicant.

The form must be word-processed. Handwritten applications will not be accepted.

All applications will be processed in strict order of date received.

If an application is missing information, or the module leader has questions or concerns about any part of the application, it will be returned to the applicant for remedial work.

Fully completed applications will be screened and scored. Successful applicants will be invited to take part in an interview. This may be telephone, video-calling or face to face, all arranged by mutual agreement.

Following interview applicants will be informed of the decision relating to the application. This will be one of the following decisions:

* an unconditional offer of a place
* a conditional offer of a place
* a requirement for remedial work on the application with a conditional offer for the next intake
* feedback and an invitation to re-apply for the next intake

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| **Part One: Applicant Details** | | | | |
| Name of Applicant: | |  | | |
| Job Title  (including grade if applicable) | |  | | |
| Date Annotated as a supplementary Prescriber | |  | | |
| Work Address  (including name of Employer / Organisation) | |  | | |
| Contact Address  (if different from above) | |  | | |
| Contact Work Phone Number | |  | | |
| Contact Mobile Phone Number | |  | | |
| Contact Email Address | |  | | |
| Who will be funding your tuition fees? (delete as appropriate) | | Self-funding / Employer / Learning Beyond Registration / Local Health Education England budget | | |
| Brief Employment History (A CV may be attached to provide this information) | | | | |
| Position Held | Date From and To | | Grade (if applicable) | Employer Details |
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| **Part Two: Area of Clinical Competence and Relevant Experience.**  The GPhC requires that pharmacists applying to undertake a supplementary prescribing conversion course must:   * be a registered pharmacist, with annotation as a Supplementary Prescriber, with the GPhC or the Pharmaceutical Society of Northern Ireland (PSNI)   AND   * provide evidence of prescribing experience within the UK that is no longer than 2 year’s old.  1. Describe below your current practice as a pharmacist on the practising register of the General Pharmaceutical Council or Pharmaceutical Society of Northern Ireland, providing evidence of relevant supplementary prescribing experience in the previous 2 years, along with information on how development of your role to an Independent Prescriber will benefit patient care.   (Max 500 words) | |
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| Describe below for which group of patients you are planning to prescribe independently and in what setting. This can include defining a group by age, or stages within a treatment guideline, and can incorporate exclusion criteria, e.g. pregnant patients. | |
| Which group(s) of patients |  | |
| Which disease state(s)? |  | |
| What speciality?  (if appropriate) |  | |
| What setting?  (e.g. hospital clinic / primary care) |  | |

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| **Part Three: Continuing Professional Development (CPD)**  Please provide a statement in support of your application demonstrating:   1. How you reflect on your own performance and take responsibility for your own CPD. 2. How you will maintain an up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to your intended area of prescribing practice. 3. How you will develop your own support network for the CPD of prescribing practice, including prescribers from other professions.   (maximum 500 words) |
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| **Part Four: Applicant Declaration**   * I confirm that I am currently fit to practise as per the GPhC/PSNI requirements. * I confirm that if there is any change to my fitness to practise status during my time as a student at DMU, I agree to inform the programme leader as soon as possible. * If successful in my application, I agree to complete the Independent Prescribing training and to use my newly acquired skills to benefit patients. * I understand that successful completion of an accredited course is not a guarantee of annotation, or of future employment, as a pharmacist independent prescriber. | |
| Printed Name of Applicant |  |
| Signature of Applicant |  |
| Date of Signature |  |

**Part Five: Supporting Statement from Designated Supervising Medical Practitioner.**

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| Name of supervising medical practitioner  (Print details) | | | |  | | | | | |
| Qualifications | |  | | GMC Registration No. | | |  | | |
| Contact Address | |  | | | | | | | |
| Contact Telephone Number | |  | | Email Address | |  | | | |
| Please supply the following information. This will assist in ensuring that the Department of Health criteria for the supervision in practice of independent pharmacist prescribers are being met.  Please delete YES / NO as appropriate. | | | | | | | | | |
| **A** | Are you a registered medical practitioner who has had at least 3 years medical, treatment and prescribing responsibility for a group of patient / service users in the relevant field of practice, as described in part three of the application form | | | | | | | | YES / NO |
| Are you: (please answer either statement **B** or **C** below): | | | | | | | | | |
| **B** | working 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 |
| **C** | a specialist registrar, clinical assistant or a consultant within an NHS Trust or other NHS employer? | | | | | | | | YES / NO |
| In addition to statement **B** or **C** above have you: | | | | | | | | | |
| **D** | 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 |
| **E** | Experience or training in teaching and / or supervision in practice? | | | | | | | | YES / NO |
| If you are not an Approved Training Practice/Institution, then please outline below your experience of teaching, supervision and assessment of students in the box below | | | | | | | | | |
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| * I can confirm that *[insert applicant’s name]* has been working as a supplementary prescriber in the last 2 years, prescribing competently in this role.\* * I have discussed the requirements of the course with [*insert applicant name*] and agree to provide supervision, support and shadowing opportunities to facilitate the achievement of the learning outcomes. * I agree to supervise [*insert applicant name*] in their prescribing role for a period of learning in practice of at least two days. * I am familiar with the General Pharmaceutical Council’s requirements and learning outcomes for the programme. | | | | | | | | | |
| Signature: | | |  | | Date: | | |  | |
| \*If the DMP is unable to make this statement, please cross it through, and get Appendix 2 completed. This statement or appendix 2 must be completed for the application to be valid. | | | | | | | | | |

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| **Part Six: Personal Statement** |
| Please provide a reflective statement outlining your decision to develop your professional role as an independent prescribing pharmacist (maximum 500 words) |
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| **Summary of Documents to Include:** | |
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| **Description of document** | **Included Y/N** |
| Copies of two fee receipts to demonstrate two full years registration with the GPhC or PSNI |  |
| Copy of undergraduate degree certificate or full academic transcript |  |
| Copy of a Supplementary Prescribing Certificate |  |
| Statement of support from a medical practitioner that confirms competence as a supplementary prescriber (either in part five or appendix 2) |  |
| Copy of postgraduate clinical pharmacy certificate / diploma / masters (if applicable) |  |
| Confirmation letter from employer that they agree to fund tuition fees (if applicable) |  |
| Confirmation that LBR / HEE funding is in place (if applicable) |  |
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| Forward Appendix 1 to your employer or referee for them to complete and send directly to the admissions tutor.  Your completed application and supporting documentation should be sent to:  Email: [hlsadmissions@dmu.ac.uk](mailto:hlsadmissions@dmu.ac.uk)  Tel: 01162577700 |  |
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| **Appendix 1: Supporting statement from employer, or in the case of a self-employed pharmacist, a referee** | | | | | | | |
| A declaration and reference is needed from the applicant’s employer, or from a pharmacist or doctor who is acting as a referee. It is anticipated that only pharmacists who are self-employed will use a referee as opposed to getting the declaration and reference from their employer. The referee can be the proposed Designated Medical Practitioner.  As the employer of, or referee for, an applicant to the Practice Certificate in Independent Prescribing for Pharmacists (Conversion Course), at De Montfort University, you are requested to provide a reference and supporting statement for the applicant. Please complete the relevant box below and sign the declaration. Please also provide a reference detailing your opinion of the applicant’s suitability to apply for the course in terms of:   * Relevant experience in the chosen area of clinical competence. * For employers only, confirmation that appropriate support and time will be given by the employer for the applicant to study, attend sessions at DMU and complete the required hours in clinical practice.   **Please return this directly to the admission tutor by post or email:**  Tim Harrison, Room 2.25p, Hawthorn Building  School of Pharmacy, Faculty of Life and Health Sciences  De Montfort University, Leicester. LE1 9BH  [tharrison@dmu.ac.uk](mailto:tharrison@dmu.ac.uk) | | | | | | | |
| To be completed by employers only | | | | | | | |
| Name | |  | | Job Title | |  | |
| Organisation | |  | | | | | |
| Contact Address | |  | | | | | |
| Contact Telephone Number | |  | Email Address | |  | | |
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| To be completed by non-employer referees only | | | | | | | |
| Name | |  | | Job Title | |  | |
| Organisation | |  | | | | GPhC / GMC Number |  |
| Contact Address | |  | | | | | |
| Contact Telephone Number | |  | Email Address | |  | | |
| I confirm that I support [*insert applicant name*] in their application to undertake the Independent Prescribing Course | | | | | | | |
| Print Name |  | | | | | | |
| Signature |  | | | Date | |  | |
| Please complete the reference on the next page.  Please provide a reference in the box below (see instructions overleaf) | | | | | | | |
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**Appendix 2: supporting statement from a medical practitioner confirming competency as a supplementary prescriber.**

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| This declaration must be completed if the designated medical practitioner in Part 5 of the application form is unable to certify the applicant’s competence as a supplementary prescriber. | | | | | | | |
| Name of medical practitioner  (Print details) | | |  | | | | |
| Qualifications |  | | GMC Registration No. | | |  | |
| Contact Address |  | | | | | | |
| Contact Telephone Number |  | | Email Address | |  | | |
| I have worked with *[insert applicant’s name]* in the capacity outlined below | | | | | | | |
|  | | | | | | | |
| * I can confirm that *[insert applicants’ name]* has been working as a supplementary prescriber in the last 2 years, prescribing competently in this role. | | | | | | | |
| Signature: | |  | | Date: | | |  |