**Professional Appendices for Independent/Supplementary Prescribing (V300) programme**

This programme is for Nurses and other AHPs wishing to undertake the Independent/Supplementary prescribing (V300) programme. **Pharmacists must apply to** [**https://www.dmu.ac.uk/study/courses/postgraduate-courses/practice-certificate-in-independent-prescribing/practice-certificate-in-independent-prescribing-for-pharmacists.aspx**](https://www.dmu.ac.uk/study/courses/postgraduate-courses/practice-certificate-in-independent-prescribing/practice-certificate-in-independent-prescribing-for-pharmacists.aspx)

As the Independent/Supplementary Prescribing (V300) programme is accredited by the Nursing and Midwifery Council (NMC) and Health Care professional Council (HCPC) there is a range of information we require from yourself so that you can demonstrate that you meet both the academic and professional requirements of entry onto this programme.

Appendix 1-7 must be returned to the Programme Leader, by email [hfield@dmu.ac.uk](mailto:hfield@dmu.ac.uk)

It is important that the clinicians supporting your application sign these forms**. A typed signature is not acceptable.**

Once the programme leader has received the professional appendices you will be invited to attended an on-line meeting with the programme leader to confirm that you meet the NMC/HCPC requirements of this programme. You cannot be enrolled onto the programme until the programme leader and admissions are assured that you meet all the entry requirements.

In addition to these appendices you will also need to complete the Standard appendices including, your Disclosure and Baring service (DBS) certificate and Good health good character form, details of your usual work base and relevant certificate to demonstrate meeting academic entry criteria. This information must be returned to admissions. You cannot be enrolled on to the programme unless all the information required has been returned.

**Check List – Applicant to complete**

|  |  |  |
| --- | --- | --- |
|  | **Please complete** | **Office use Only** |
| Applicants Name |  |  |
| Profession of Applicant |  |  |
| NMC/HCPC PIN  Pharmacists must apply to the relevant programme |  |  |
| DATE of Qualification |  |  |
| Are you working at an advanced Level? |  |  |
| Is English your first Language?  If not, you must possess  **either** the International English Language Testing System (IELTS) with a minimum score of 7.0 **OR** have studied at degree level in a UK university. | **Yes**  **No**  **If No IELTS Score?**  **Or Details of study at UK university?** |  |
| Name of Practice Assessor- |  |  |
| GMC/NMC/HCPC PIN of Practice Assessor |  |  |
| Name of Practice Supervisor |  |  |
| GMC/NMC/HCPC PIN of Practice Supervisor |  |  |
| Name of CPD facilitator |  |  |
| GMC/NMC/HCPC PIN of CPD Facilitator |  |  |
| Name of Clinician who confirmed proficiency to start Programme |  |  |
| GMC/NMC/HCPC PIN of Clinician confirming skills to start the programme |  |  |
| Name of Managerial Support or Declaration by self-employed applicant |  |  |
| Name of Trust NMP Lead  or Name of person providing Professional Reference (self-employed students only) |  |  |
| Intended Level of study | **Degree/ Masters** |  |
| Studying as part a Programme? | **Y/N**  **If yes name of programme** |  |

**APPENDIX 1 - SELF DECLARATION BY PRESCRIBING APPLICANT**

|  |  |  |
| --- | --- | --- |
| **Name of applicant** |  | |
| As a pre-requisite to attending the prescribing course the NMC (2018) state that you must be competent in the following areas:   * Clinical /health assessment * Diagnostics /care management * Planning and evaluation of care | | |
|  | | **Please tick one box** |
| I have undertaken a post registration university accredited course that covers clinical assessment, diagnosis, planning and evaluation of care  **Name of University:**  **Name of Module:**  **Date passed:** | |  |
| I have not undertaken a post registration university accredited course that covers clinical assessment, diagnosis, planning care and evaluation of care  If you do not have a course in clinical assessment, diagnosis, planning and evaluation of care please provide a portfolio of evidence of how you have developed and maintained your competencies in these skills. You should include details of how you have been assessed in practice.  **Please be aware that these skills are not taught as part of the prescribing programme so it is essential that you are competent in these areas before starting the programme. This portfolio will need to be brought to your interview to verify that you have the relevant skills** | |  |
|  | | **Please Sign** |
| I am competent to undertake a clinical assessment, diagnosis, planning and evaluation of care for a patient within my speciality | |  |
| I understand that I will need to spend 12 days working in a supernumerary capacity in practice. | |  |
| I understand that I must attend all lectures and must make up any missed theory or practice hours. | |  |
| I understand that on completion of the programme I cannot prescribe until my prescribing qualification is annotated by the NMC/HCPC | |  |
| I understand that on completion of the programme, I can only prescribe within my area of competence and scope of professional practice | |  |

**APPENDIX 2–PRACTICE ASSESSORS DETAILS –**

**To be completed by Prescribing Practice Assessor**

The role of practice assessor and supervisor should be undertaken by different people.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of applicant**  **(Nurse/Midwife/HCPC)** | |  | | | | | | |
| **Name of Practice Assessor** | |  | | | | | | |
| **Job title** | |  | | | | | | |
| **Profession** | |  | **GMC/NMC/HCPC registration no:** | | | |  | |
| **Trust:** | |  | | | | | | |
| **Work address:** | |  | | | | | | |
| **Telephone number:** | |  | | **Email address** |  | | | |
| **Eligibility criteria for Practice Assessor for a nurse/midwife prescribing student** | | | | | | | | **Please tick** |
| I am a prescriber either Doctor or Dentist or a Nurse/Midwife or Allied Health Professional with V300 independent prescriber qualification | | | | | | | |  |
| I have been practicing as a prescriber for at least 3 years | | | | | | | |  |
| I have experience or training in teaching and assessing in practice. | | | | | | | |  |
| I have experience in a relevant area of practice to the applicants speciality | | | | | | | |  |
| I have read and understood the information on the Placement Hub <http://placementhub.our.dmu.ac.uk/> After their interview the applicant will be sent a supervisor/assessor handbook which they will forward on to you. If you require further information/clarification on your role please email the programme leader [hfield@dmu.ac.uk](mailto:hfield@dmu.ac.uk) to arrange a suitable time for an online update. | | | | | | | |  |
| I will provide supervision, support and opportunities for the applicant to meet the standards contained within the Competency Framework for all Prescribers (Royal Pharmaceutical Society, 2016) | | | | | | | |  |
| I understand that I have a duty to uphold patient safety and I must raise any professional or competency concerns with the applicants manager and programme leader | | | | | | | |  |
| I confirm there is no conflict of interest in undertaking the role of practice assessor for this applicant | | | | | | | |  |
| I understand that my professional registration will be checked as part of the admissions process | | | | | | | |  |
| **Signature** |  | | | | | **Date** | |  |

**APPENDIX 3 – PRACTICE SUPERVISORS DETAILS**

**To be completed by Practice Supervisor**

The role of practice assessor and supervisor should be undertaken by different people.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of applicant** | |  | | | | | |
| **Name of Practice Supervisor** | |  | | | | | |
| **Job title** | |  | | | | | |
| **Profession** | |  | **GMC/NMC/HCPC PIN** | | |  | |
| **Trust:** | |  | | | | | |
| **Work address:** | |  | | | | | |
| **Telephone number:** | |  | | | | | |
| **Email address:** | |  | | | | | |
| **Eligibility criteria for Practice Supervisor** | | | | | | | **Please tick** |
| I am a prescriber either Doctor or Dentist or a Nurse/Midwife or Allied Health Professional with V300 independent/supplementary prescribing qualification | | | | | | |  |
| I have been practicing as a prescriber for at least 2 years | | | | | | |  |
| I have experience or training in teaching and supervising in practice. | | | | | | |  |
| I have experience in a relevant area of practice to the applicants speciality | | | | | | |  |
| I have read and understood the information on the Placement Hub <http://placementhub.our.dmu.ac.uk/> After their interview the applicant will be sent a supervisor/assessor handbook which they will forward on to you. If you require further information/clarification on your role please email the programme leader [hfield@dmu.ac.uk](mailto:hfield@dmu.ac.uk) to arrange a suitable time for an online update. | | | | | | |  |
| I will provide supervision, support and opportunities for the applicant to meet the standards contained within the Competency Framework for all Prescribers (Royal Pharmaceutical Society, 2016) | | | | | | |  |
| I understand that I have a duty to uphold patient safety and I must raise any professional or competency concerns with the applicants manager and programme leader | | | | | | |  |
| I confirm there is no conflict of interest in undertaking the role of practice supervisor for this applicant | | | | | | |  |
| I understand that my professional registration will be checked as part of the admissions process | | | | | | |  |
| **Signature** |  | | | **Date** |  | | |

**APPENDIX 4 – CONTINUING PROFESSIONAL DEVELOPMENT (CPD) FACILITATOR**

**To be completed by CPD facilitator**

Applicants are required to have the support of a health care professional prepared to act as a prescribing continuing professional development facilitator. The purpose of the facilitator is to provide support and advice to the applicant on prescribing during for the first year post qualification as a prescriber. The competency frame work for all prescribers (Royal Pharmaceutical Society, 2016) should be used as the basis for the reflection required as part of the CPD process.

The CPD facilitator must be a registered healthcare professional and an experienced prescriber (has been prescribing for a minimum of 2 years.) The continuing professional development facilitator may be the same person as either the prescribing practice assessor or prescribing practice supervisor.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicants name** |  | | |
| **Continuing professional development facilitator** |  | | |
| **Job title** |  | | |
| **GMC/NMC/HCPC registration number** |  | | |
| **Date qualified as**  **prescriber** |  | | |
| **Work address** |  | | |
| **E-mail address** |  | | |
| **I am willing to act as a continuing professional development facilitator to this applicant on the Prescribing Programme.** | | | |
| **Signature** |  | **Date** |  |

**APPENDIX 5 - PROFICIENCY TO START PRESCRIBING PROGRAMME**

**To be completed by the practice assessor/practice supervisor**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Applicants name** | |  | | | |
| As a pre-requisite to attending the prescribing course the NMC (2018) states that the applicant must be competent in the following areas:   * Clinical /health assessment * Diagnostics /care management * Planning and evaluation of care   Please give evidence of how you have assessed the applicant’s competencies in these areas. | | | | | |
| **Within the applicant’s area of competency, I confirm that they are able to:** | | | | | **Please sign to confirm** |
| **Take an appropriate medical, social and medication history** | | | | |  |
| **Undertake an appropriate clinical assessment** | | | | |  |
| **Interpret relevant patient records** | | | | |  |
| **Understand the working or final diagnosis by systematically considering all possibilities** | | | | |  |
| **Practice assessors/designated medical practitioner name** | | |  | | |
| **Profession** |  | | **GMC/NMC/HCPC registration no:** |  | |
| **Signature** | | |  | | |

**APPENDIX 6A - MANAGERIAL SUPPORT**

To be completed by applicants manager.

**If applicant is self-employed please complete appendix 6B instead**

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicants Name** |  | | |
| **Name of manager/** |  | | |
| **Job title** |  | | |
| **Profession** |  | **GMC/NMC/HCPC PIN** |  |
| **I confirm that this applicant:** | | | **Please sign** |
| Will be given time to attend at taught sessions (19 days) | | |  |
| Will be given time working in a supernumerary capacity (12 days) | | |  |
| The applicant has is a suitable candidate to undertake the Independent/ supplementary prescribing programme | | |  |
| The applicant has a clear, enhanced DBS within the last three years/ I am aware of any disclosures and do not consider that this should preclude the applicant from undertaking this programme. | | |  |
| **Signature** | | |  |

**APPENDIX 6B -DECLARATION BY SELF-EMPLOYED STUDENT ONLY (not required for employed students**

To be completed by **self-employed students only** in place of appendix 6A

|  |  |  |
| --- | --- | --- |
| **Applicants name** |  | |
| **Work address** |  | |
| **E-mail address** |  | |
|  | | **Please Sign** |
| **I declare that I am self-employed and do not have a Line Manager or Non-Medical Prescribing Lead** | |  |
| **I declare that my scope of practice is covered by my professional regulator** | |  |
| **I declare that I have Professional Indemnity Insurance sufficient to cover all liability risks associated with my practice** | |  |
| **I declare that I am an active and compliant member a Professional Standards Register** | |  |

**APPENDIX 7a – NON MEDICAL PRESCRIBING (NMP) LEAD SUPPORT**

To be completed by the Non-Medical Prescribing Lead.

If applicant is self-employed Appendix 7a may be omitted, but appendix 7b – Professional Reference completed instead

|  |  |
| --- | --- |
| **Applicants name** |  |
| **I agree to support the applicant to undertake the prescribing module** | |
| **Non-Medical Prescribing Lead Name** |  |
| **Trust** |  |
| **Work address** |  |
| **Email address** |  |
| **NMP Lead signature** |  |
| **Date** |  |

**Non-Medical Prescribing Leads:**

UHL – Hannah Flint, [hannah.flint@uhl-tr.nhs.uk](mailto:hannah.flint@uhl-tr.nhs.uk),

LPT – Joanne Charles [Joanne.Charles@leicspart.nhs.uk](mailto:Joanne.Charles@leicspart.nhs.uk)

If you are employed by a GP practice, your NMP Lead relates to your Clinical Commissioning Group (CCG):

Leicester City CCG [Wendy.Hope@LeicesterCityCCG.nhs.uk](mailto:Wendy.Hope@LeicesterCityCCG.nhs.uk);

East Leics and Rutland CCG Vishal Mashru [vishal.mashru@eastleicestershireandrutalndccg.nhs.uk](mailto:vishal.mashru@eastleicestershireandrutalndccg.nhs.uk)

West Leicestershire CCG Manjeet Garcha [Manjeet.Garcha@westleicestershireccg.nhs.uk](mailto:Manjeet.Garcha@westleicestershireccg.nhs.uk)

**APPENDIX 7b – PROFESSIONAL REFERENCE**

To be completed **by students who are self-employed or where Trust /CCG does not have a Non-Medical prescribing Lead instead of appendix 7a**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicants name** |  | | | |
| **Reference for applicant by a Registered Health Care Professional on applicants suitability to undertake the Independent/Supplementary Prescribing Programme** | | | | |
| **Profession of referee?**  **You must be a Doctor or Dentist or a Nurse/Midwife/Allied Health Professional with Independent/Supplementary Prescribing qualification** | |  | | |
| **In what capacity have you worked with the applicant?** | |  | | |
| **Dates that you worked with the applicant?** | |  | | |
| **Do you have any reason to consider that the applicant would not be a suitable candidate for the Independent/Supplementary Prescribing Programme?** | |  | | |
| **Is there any conflict of interest for you in undertaking the role of referee for this applicant?** | |  | | |
| **I understand that my professional registration will be checked as part of the admissions process** | |  | | |
| Please comment on the applicant suitability to be enrolled on the Independent/Supplementary Prescribing Programme | | | | |
| **REFEREES NAME** |  | | | |
| **REFEREES PROFESSION** |  | | | |
| **GMC/NMC/HCPC NUMBER** |  | | | |
| **Signature** |  | | **Date** |  |