INDEPENDENT AND SUPPLEMENTARY PRESCRIBING APPLICATION
This Application must be completed fully to obtain funding

NAME OF APPLICANT:

COURSE FOR WHICH APPLYING: (Please tick appropriate box):

INDEPENDENT/SUPPLEMENTARY PRESCRIBING FOR: Nurses and midwives

GENERAL GUIDANCE NOTES

- PLEASE READ THE FOLLOWING DOCUMENTS FOR INFORMATION ABOUT THE FRAMEWORKS FOR NON-MEDICAL PRESCRIBING
  
  Prescribing Guidance from the NMC
  HTTPS://WWW.NMC.ORG.UK/GLOBALASSETS/SITEDOCUMENTS/STANDARDS/NMC-STANDARDS-PROFICIENCY-NURSE-AND-MIDWIFE-PREScriBERS.PDF
  
  Department of Health - Supply and distribution of medicines to patients
  
  Supplementary prescribing guidance FROM THE DEPARTMENT OF HEALTH

- PLEASE READ PROCESS FOR APPLICATION CAREFULLY ON PAGE 2.

- DISCUSS INTENTION OF UNDERTAKING THE COURSE WITH YOUR ORGANISATION PRESCRIBING LEAD PRIOR TO COMPLETING THE APPLICATION (NON-MEDICAL PRESCRIBING HAS TO BE APPROPRIATE FOR YOUR ROLE AND THE SERVICE).

- CONTACT UNIVERSITIES DIRECT FOR INFORMATION ON THEIR PRESCRIBING COURSE (APPLICANTS CANNOT TRANSFER TO OTHER UNIVERSITIES ONCE HAVE COMMENCED A COURSE).

- PLACES CANNOT BE RESERVED; THE ONLY GUARANTEE OF A PLACE IS A COMPLETED APPLICATION FORM.

- APPLICANTS WILL NEED TO SEEK PERMISSION FROM THEIR ORGANISATION’S TRAINING PANEL, IN ADDITION TO COMPLETING THIS APPLICATION.

- ANY INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT UNSIGNED.

- YOU ARE RESPONSIBLE FOR DISCLOSING IF:
  A) YOU ARE THE SUBJECT OF ANY CURRENT PROFESSIONAL INVESTIGATION.
  B) IF YOU HAVE UNSUCCESSFULLY ATTEMPTED THIS MODULE AT ANOTHER HEI.

- AN ELECTRONIC VERSION OF YOUR COMPLETED APPLICATION FORMS (INCLUDING E-SIGNATURES IF PREFERRED) SHOULD BE EMAILED TO THE POST REGISTRATION ADMIN TEAM AT POSTREG_ADMIN@SURREY.AC.UK
**PROCESS OF APPLICATION**

**INDIVIDUAL OBTAINS APPLICATION FROM CCG/NHS TRUST LEAD FOR NON-MEDICAL PRESCRIBING**

- Will non-medical prescribing benefit specified patient/client group?
- Has applicant access to prescribing budget?
- Does applicant fit the academic and clinical criteria?

**APPLICANT MEETS WITH ORGANISATION MANAGER TO DISCUSS APPLICATION**

- Will non-medical prescribing benefit specified patient/client group?
- Has applicant access to prescribing budget?
- Have adequate arrangements been made by the CCG/NHS Trust for staff cover whilst applicant undertaking course or consideration given to the impact on clinical workload?
- Is course funding available?

**THE RELEVANT INDEPENDENT PRESCRIBERS (DOCTORS) HAVE AGREED TO SUPPORT INTRODUCTION OF SUPPLEMENTARY PRESCRIBING FOR SPECIFIED GROUP OF PATIENTS (IF APPLICABLE)**

**THE APPLICANT HAS IDENTIFIED A DESIGNATED MEDICAL PRACTITIONER (DOCTOR) TO TEACH AND ASSESS IN PRACTICE**

**APPLICANT COMPLETES THE APPLICATION FORM (OBTAINED FROM NON-MEDICAL PRESCRIBING LEAD)**

**APPLICATION TO BE SIGNED BY APPLICANT, LINE MANAGER AND DESIGNATED MEDICAL PRACTITIONER**

**APPLICATION (PRIOR TO HEI SIGNATURES) TO BE FORWARDED TO:**

**NON-MEDICAL PRESCRIBING LEAD FOR ORGANISATION FOR SIGNATURE**

**NON-MEDICAL PRESCRIBING LEAD FORWARDS APPLICATION TO IDENTIFIED UNIVERSITY APPLICANT AND PRESCRIBING LEAD NOTIFIED THAT FUNDING HAS BEEN AGREED**
TO BE COMPLETED BY APPLICANT

Mr/Mrs/Ms/Miss/Dr (*delete as appropriate)

APPLICANT NAME: (print)

CURRENT JOB TITLE:

NMC *
Pin Number: Expiry Date: (*delete as appropriate)

Are you the subject of any current professional investigation
Yes ☐ No ☐

Have you previously attempted this module at another HEI
Yes ☐ No ☐

Date of Birth: (This is required to check registration with your regulatory body following qualification)

Work Address: (Include name of Organisation Trust/CCG etc)

Home Address:

Work Tel Number: Home Tel Number:

Mobile Number: E-mail:

Computer Access

Do you have access to a computer? Yes ☐ No ☐

Will the access be through: Home Yes ☐ No ☐

Work Yes ☐ No ☐

More information regarding computer access may be required at interview.
TO BE COMPLETED BY APPLICANT

Which Clinical/Practice areas are you currently working in?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

For which group of patients will you prescribe?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

What disease/therapeutic areas?

_________________________________________________________________________
_________________________________________________________________________

What specific unmet needs have you identified for these patients that you feel would be met by your ability to prescribe?

_________________________________________________________________________
_________________________________________________________________________

What setting (Acute/GP/NHS/Private Sector/Prison Service etc)

_________________________________________________________________________
_________________________________________________________________________

Are you currently undertaking any other programme of study? Yes/No

If Yes, please state which programme and indicate when you will be completing

_________________________________________________________________________
_________________________________________________________________________
PREVIOUS QUALIFICATIONS
Please note: You **MUST** provide evidence that you are able to study at level 6 (degree level)

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<th>Professional Healthcare Qualifications:</th>
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<td>Qualification</td>
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| Academic qualifications e.g. Diploma, Degree, Masters |
| (Please send photocopies of your certificates)        |
| Qualification | Level | Date Obtained | Awarding Body |
|              |       |               |               |
|              |       |               |               |

At what academic level do you wish to undertake the Independent and/or Supplementary Non-medical Prescribing training?

- Level 6
- Level 7 (Masters)

**PLEASE WRITE BRIEF STATEMENT IN SUPPORT OF YOUR APPLICATION**

**PLEASE REFLECT AND OUTLINE**

- WHAT HAS LED YOU TO APPLY?
- THE SERVICE YOU WILL BE PROVIDING
- THE SKILLS YOU WILL BRING TO THE ROLE
- THE BENEFITS FOR THE PATIENT AND THE NHS
- HOW DOES NON-MEDICAL PRESCRIBING FIT INTO THE DEVELOPMENT OF YOUR PRACTICE?
- SUPPORT NETWORKS ACCESSIBLE TO YOU
- **IF YOU ARE CURRENTLY PRACTISING AS A PHARMACIST SUPPLEMENTARY PRESCRIBER, PLEASE PROVIDE DETAILS OF RELEVANT PATIENT ORIENTATED PRACTICE**

( PLEASE CONTINUE ON REVERSE OF THIS SHEET AS REQUIRED APPROX 300 WORDS)
Please tick all the following statements to confirm:

The applicant is an employee with a minimum of 3 years (2 years for pharmacists) post-registration clinical experience (or part time equivalent), of which at least one year immediately preceding their application to the training programme has been in the clinical area in which they intend to prescribe.

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<th>Yes</th>
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The applicant will be given full study time to attend the university programme, together with the 12 days supervised practice with their DMP or identified supervisor. Distance/E learning applicants must be given a minimum of 10 days additional protected study time in addition to the face to face contact at the university.

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The applicant has successfully completed a module that includes diagnostic, examination and consultation skills or equivalent. For example Health Assessment Module (level 6 or level 7).

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There is clinical need for the applicant to prescribe within their current role.

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The applicant demonstrates appropriate numeracy skills (to be further developed within the context of prescribing and assessed on the course).

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The applicant will be in a position to prescribe on completion of training and have access to a prescribing budget.

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The applicant will be supported with appropriate CPD once they are qualified.

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Where appropriate, the applicant has the agreement of the independent medical prescriber to undertake supplementary prescribing with a patient group.

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The applicant has had a Disclosure & Barring Service Check that is current and satisfactory within the last 3 years.

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Date of DBS: Please send a copy of your DBS certificate with your completed application form.

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I agree to support the applicant for this course of study

NAME (print):

Current Job Title:

Signature: Date:

Contact Address: ____________________________________________________________

I agree that this application is appropriate for patient services

NAME (print):

Signature: Date:
# AGREEMENT WITH DESIGNATED MEDICAL PRACTITIONER (DMP)

**PLEASE COMPLETE ALL CONTACT DETAILS**

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<tr>
<th>Name of Medical Practitioner:</th>
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<tbody>
<tr>
<td>Contact Tel Number:</td>
<td>E-mail Address:</td>
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<tr>
<td>Work Address:</td>
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<td>Qualifications:</td>
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Please supply the following information to ensure the Department of Health criteria is met for the supervision in practice for prescribers by medical assessors. Please tick the appropriate boxes.

**DH (Nov. 2001) Criteria:** Are you a registered medical practitioner who:

(i) has normally had at least 3 years medical, treatment and prescribing responsibility for a group of patient/clients in the field of practice that the applicant will prescribe.  

and are you:

(ii) 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?  

Or  

a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer?

and have you:

(iii) 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?  

and have you:

(iv) some experience or training in teaching and/or supervision in practice?

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

________________________________________________________________________

_____________________________________________  

I confirm that the applicant is competent as a supplementary prescriber (for SP to IP conversion course pharmacists only).  

I confirm that I have agreed to supervise, support and assess the applicant for a **minimum of TWELVE DAYS** in the development of their prescribing role during clinical placement.

**Signature:**  

**Date:**  

**GMC Registration Number:**  

**NB:** The DMP must disclose to the NMP lead if they are currently the subject of any professional investigation.
PREFERRED COURSE PROVIDER
Please give your first and second choice of provider and start date.

Preferred Course Provider:                                                      Start Date:

1st

2nd

APPLICANT STATEMENT

If successful in my application, I agree to complete the Independent Prescribing/ Supplementary
Prescribing (please delete if not applicable). I further agree to utilise my prescribing skills to benefit
patients and the NHS.

NAME (print)                                                      

Signature:                                                                 Date: 

INVOICE TO BE SENT TO:

Name:                                                                 

Address:                                                               

Post Code:                                                            

TO BE COMPLETED BY HIGHER EDUCATION INSTITUTION

Application Agreed     Application Refused

Comments:                                                    

NAME (print):                                        

Title:                                                     

Signature:                                              Date: