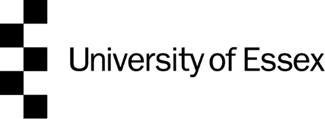
**School of Health and Social Care**

**HS632 Preparation for Independent and Supplementary Prescribing**

**V300 Application Form –** NMC Applicants

Please complete your application form on word (type your responses). All sections must be completed with either a ‘wet’ signature or ‘electronic’ signatures. (typed names cannot be accepted as a signature)

Please refer to Section 12 for guidance on completing the application form.

|  |
| --- |
|  |

**Start Date:**

**Please indicate Level of study:** (To study at level 7, you must have successfully completed a BSc or studied a level 6 module)

|  |  |
| --- | --- |
| **Level 6 - degree** |  |
| **Level 7 - masters** |  |

**Please indicate your role:**

|  |  |
| --- | --- |
| **Level 1 Nurse** |  |
| **SCPHN** |  |

**Please Provide your NMC Pin, Date of Registration & Full Name** *(as appears on the NMC Register):*

|  |  |  |  |
| --- | --- | --- | --- |
| **NMC Pin:** |  | **Date of First Registration:** |  |
| **Full Name:** *(as appears on the NMC Register)* | |  | |

**1. Personal Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Title:** | | Mr / Mrs / Miss / Ms *(indicate as appropriate)* | | | | |
| **Surname:** | |  | | | | |
| **Other Names:** | |  | | | | |
| **Former Name** *(if applicable):* | |  | | | | |
| **Date of Birth:** |  | | **Country of Birth:** | |  | |
| **Nationality** *(as shown on passport):* | |  | | | | |
| **Home Address** *(including post code):* | |  | | | | |
| **Contact Number:** |  | | | **Email Address:** | | *Course information will be sent to this email address.* |

**Academic and Professional Qualifications** *(most recent first)*

| Date of award | Awarding Institution | Course Title/Subject | Result |
| --- | --- | --- | --- |
|  |  |  |  |

**Employment History** *(maximum of 5 years, most recent first)*

| Dates of employment | Place of employment | Job Title |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Current Employer Details**

|  |  |
| --- | --- |
| Current Employer Name: |  |
| Employer address: *(including post code)* |  |
| Contact Number: |  |

In no more than 200 words, please explain in the box below, how this qualification will benefit your current working environment / department / service and the patients you currently care for.

|  |
| --- |
|  |

To be eligible to attend the course, applicants are required to be competent in in clinical assessment, diagnosis, planning and evaluation of care. Please summarise below, how you have developed and maintained these skills.

|  |
| --- |
|  |

**2. Funding**

**Please indicate funding type:** *(please indicate as appropriate)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employer Funded |  | Self Funded |  | NHS England |  | Apprenticeship |  | Other |  |

|  |  |
| --- | --- |
| Where funding is indicated as ‘Other’, please specify**:** |  |

*Self funded applicants pay the full course fee online approximately 1 week before registering on to the course. Payment details will be provided by the Course Administrator prior to the course commencing. Payment can be made by credit card, debit card or bank transfer. The University does not offer payment terms via instalments.*

*Self funded applicants continue to section 3.*

**2a. Employer Funded Invoice Details** *– to be provided by person / team authorising the funding. PO/Ref can be applicants name if employer does not have a purchase order system in place.*

|  |  |
| --- | --- |
| Employer invoice address & post code: |  |
| Invoice email address: |  |
| Purchase order number / reference:  *(if known)* |  |

**2b. Employer Funding Authorisation –** *To be completed by the individual authorising the funding for the course fee.*

|  |  |
| --- | --- |
| Name of authorising member of staff: |  |
| Email address: |  |
| Contact number: |  |
| Signature of authorising member of staff: |  |
| Date signed: |  |

If you have any queries relating to funding, please e-mail [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk)

1. **Line Manager Confirmation** *- Line Manager to complete, date & sign – For Self-Funded applicants who are not NHS employed, Practice Assessor to complete, date & sign this section.*

| Line Manager Confirmation | | | Yes | No |
| --- | --- | --- | --- | --- |
| Is the applicant a level 1 registered nurse or SCPHN registered with the NMC? | | |  |  |
| Does the applicant have a recognised qualification/experience and ability to enable them to apply non-medical prescribing skills to their intended area of prescribing practice? | | |  |  |
| Does the applicant have evidence of the ability to study at the level indicated on page 1 of this application form? Level 6 (degree level), Level 7 (masters level) | | |  |  |
| Does the applicant have at least 1 year’s FTE post-registration experience and are they deemed competent by their employer\*? | | |  |  |
| Does the applicant have a trained Practice Assessor willing to oversee the 12 days (90 hours) of practice relevant to his/her field of ‘learning in practice’? | | |  |  |
| Are you able to confirm that the applicant is of good character and of good health to study on the prescribing course? | | |  |  |
| Has employer given commitment to candidate’s attendance on the programme?  This consists of 26 taught days over a period of 6 months (one day a week) | | |  |  |
| All applicants must have the following advanced practice skills:   * Clinical and health assessments * Diagnostics and care management * Planning and evaluation of care   **Can you confirm that the applicant is practising at an advanced level and is proficient in the above skills?** | | |  |  |
| Has the applicant previously commenced but not completed a prescribing course?  *If yes please confirm the following:*   * Place of study: * Date course attended:   *Please note: Recognition of prior learning cannot be considered on this programme.* | | |  |  |
|  | | | Yes | No |
| ***In addition to the section above, the following questions must be completed by the Practice Assessor for applicants who are Self-Funded & not employed within the NHS*** *(to be completed by Practice Assessor, within the placement provider)*  Does the applicant have a **contract of employment or honorary contract**? *(copy to be provided when submitting the application form)* | | |  |  |
| Does the applicant have **professional indemnity** arrangements in place for their prescribing practice?  *Copy of indemnity cover to be provided with the application, indicating the applicant is covered by the organisation providing the placement.* | | |  |  |
| Is the placement provider **CQC registered**?  *A CQC inspection must have been carried out and a copy of the CQC report available. Copy of the CQC report is required and to be provided with the application.* | | |  |  |
| Practice Assessor to provide 2 **professional references** for the applicant - to be submitted with the application form. (*reference template provided at the end of the application form)* | | |  |  |
| **Line Manager’s Full Name:** *OR for Non-NHS employed: Practice Assessor/Educator Full Name:* | |  | | |
| Work Address: |  | | | |
| Email Address: |  | | | |
| Contact number: |  | | | |
| Signature *(wet / electronic):* |  | | | |
| Date signed: |  | | | |

1. **Practice Placement Quality Assessment -** *Line Manager to complete, date & sign – For Self- Funded applicants who are not NHS employed, Practice Assessor to complete & sign section.*

| Line Manager Statement | Yes | No |
| --- | --- | --- |
| 1. Our policies and procedures within our practice placement areas reflect health and safety legislation, employment legislation and equality of opportunity. |  |  |
| 1. Our human resources management processes reflect good practice in relation to recruitment, retention, development of staff and equal opportunities. |  |  |
| 1. Our staff understand and manage specific risks to students and risk assessment is carried out in practice placement areas. |  |  |
| 1. We ensure that students have access to educational and IT facilities, including internet access, (where practical) when they are on placement. |  |  |
| 1. We have mechanisms in place in placement areas to recognise early poor performance of students and for taking appropriate and prompt action. |  |  |
| 1. We provide all students with a named Practice Assessor for the duration of the placement, the PA is appropriately qualified and meets the relevant regulatory body requirements. |  |  |
| 1. In addition to the PA we provide all NMC students with a named Practice Supervisor for the duration of the placement, Practice Supervisors are appropriately qualified and meet the SSSA standard for student supervision - NMC (2018). |  |  |
| 1. Our Practice Placement Supervisors are aware of the student’s placement outcome as outlined in the [Royal Pharmaceutical Society Framework for Prescribers](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030). They are able to agree with the student an individual learning contract for their prescribing placement experience. |  |  |
| 1. Scheduled appointments will be made with Practice Supervisors to discuss progress towards learning outcomes. |  |  |
| 1. We take action on evaluation/feedback information that students give us on the quality of their placement and practice placement supervision as required. |  |  |
| 1. Practice placement provides varied learning opportunities that enable students to achieve learning outcomes through observing skilled professionals prescribe; participation under direct supervision in an environment that respects users’ rights, privacy and dignity. |  |  |

|  |  |
| --- | --- |
| **I confirm all the above standards can be met whilst the student undergoes practice supervision.** *Line Manager**to complete & sign**OR for Non-NHS employed: Practice Assessor/Educator Full Name & signature.* | |
| Full Name: |  |
| Please confirm Role: |  |
| Signature *(wet / electronic):* |  |
| Date signed: |  |

1. **Practice Assessor Details –** *Practice Assessor to complete, date and sign section. Please ensure your contact details are correct, as the Module Lead will be in contact prior to/during the course.*

|  |  |  |
| --- | --- | --- |
| **Full Name** *(as shown on professional registration)* | **First Name:** | **Surname:** |
|  |  |
| **Area of Practice** |  | |
| **Job Title:** |  | |
| **Professional Registration Number:**  *(GMC / HCPC / NMC / PSNI)* |  | |
| **Regulatory Body:** |  | |
| **Date of First Registration:** |  | |
| **Trust / Employer Name**: |  | |
| **Work Address:** |  | |
| **Contact Number:** |  | |
| **Email Address:** |  | |

1. **Practice Assessor (PA) Confirmation** *– PA to complete, date and sign section.*

|  |  |  |  |
| --- | --- | --- | --- |
| Practice Assessor Confirmation | Yes | | No |
| A prescriber who is taking on the PA role must be registered with the professional regulator for a minimum of **3 years**. Do you meet this requirement? |  | |  |
| Do you meet all of the competencies within the [Competency Framework for all Prescribers](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030)? |  | |  |
| Please confirm that you:Demonstrate commitment to supporting the applicant throughout the prescribing course. |  | |  |
| In relation to **skills and knowledge,** please confirm that you:   * Work in line with legal, regulatory, professional and organisational standards as an experienced and active prescriber. * Are an experienced prescriber in a patient-facing role. * Are an active prescriber in a patient-facing role, with appropriate knowledge and experience in an area of practice relevant to the prescribing trainee. * Have knowledge of the scope and legal remit of non-medical prescribing and the NMP trainee profession. |  | |  |
| * Can articulate decision-making processes and justify the rationale for decisions when teaching or training others. * Have knowledge of a range of methods of assessment and experience of conducting assessment of trainees in clinical practice. * Can deliver timely and regular constructive feedback. * Can facilitate learning by encouraging critical thinking and reflection. |  | |  |
| Practice Assessor Confirmation - continued | | Yes | No |
| In relation to **partnership working**, please confirm that you:   * Work with the prescribing trainee to establish their baseline knowledge and skills and jointly create a development plan for meeting and learning outcomes. * Regularly assess the prescribing trainee at appropriate intervals to guide gradual handover of elements of the process that lead to prescribing decisions. * Work in partnership with the prescribing trainee, other practitioners, and the programme provider to confirm the competence of the trainee. * Recognise own limits and capacity, knowledge and skills and areas of practice where other practitioners may be better placed to support learning. * Advocate and facilitate a multidisciplinary team (MDT) approach to training by encouraging the prescribing trainee to learn from other appropriate practitioners. | |  |  |
| In relation to ensuring an appropriate **learning environment,** please confirm that you:   * Negotiate sufficient time to support the trainee throughout their period of learning in practice. * Encourage an environment that promotes equality, inclusivity, and diversity. * Create a safe learning culture that encourages participation and open discussion to support learning. | |  |  |
| In relation to **governance**, please confirm that you:   * Acknowledge your role and responsibilities within the wider governance structure, including the programme provider, employing organisation, professional regulator, and others. * Ensure familiarity with the process of escalating concerns about a prescribing trainee and, where appropriate, engage with this process. * Engage with the employing organisation (or equivalent) to ensure support and resources are available to undertake the PA role. * Participate with the programme provider by completing placement audits as required. * Are aware of your duty of care to inform the University of Essex of any concerns of the applicant being ‘fit to practice’ during the course. | |  |  |
| * Are you familiar with the requirements of the programme and the need for the applicant to achieve the learning outcomes? | |  |  |

|  |  |  |
| --- | --- | --- |
| As the Practice Assessor, I agree to validate 12 days (90 hours) by assessing and observing the NMP student. This may include working with/observing directly and gaining feedback from a range of prescribing supervisors. | | |
| Name of Practice Assessor completing this form: | |  |
| Relationship to applicant: | |  |
| Email address: |  | |
| Contact number: |  | |
| Signature (wet / electronic signature): |  | |
| Date signed: |  | |

1. **Practice Supervisor Details -** *To be completed, dated & signed by Practice Supervisor. Please ensure your contact details are correct as the Module Lead will be in contact prior to/during the course.*

|  |  |  |
| --- | --- | --- |
| **Full Name:** *(as shown on professional registration)* | **First Name:** | **Surname:** |
|  |  |
| **Area of Practice** |  | |
| **Job Title:** |  | |
| **Professional Registration Number:** *(GMC / HCPC / NMC / PSNI)* |  | |
| **Regulatory Body:** |  | |
| **Date of First Registration:** |  | |
| **Trust / Employer Name:** |  | |
| **Work Address:** |  | |
| **Contact Number:** |  | |
| **Email Address:** |  | |

1. **Practice Supervisor –** *Practice Supervisor to complete, date and sign section.**Please tick to show that you agree to the following statements, which align to the NMC Standards for the Prescribing Programme.*

|  |  |  |
| --- | --- | --- |
| Practice Supervisor Statement | Yes | No |
| As a Practice supervisor, you must be qualified as a V300 prescriber for a minimum of 1 year. |  |  |
| I agree to serve as a role model for safe and effective practice in line with the NMC and HCPC code of conduct. |  |  |
| I agree to support learning in line with my scope of practice to enable the student to meet their proficiencies and programme learning outcomes. |  |  |
| I agree to support and supervise students, providing feedback on their progress towards, and achievement of proficiencies and skills. |  |  |
| I have current knowledge and experience of the area in which I am to provide support, supervision, and feedback. |  |  |
| I agree to be prepared to receive ongoing support to participate in the practice learning of students. |  |  |

|  |  |  |
| --- | --- | --- |
| Practice Supervisor Statement - continued | Yes | No |
| I agree to be prepared to receive ongoing support to participate in the practice learning of students. |  |  |
| I agree to contribute to the student record of achievement by periodically recording relevant observations on the conduct, proficiency and achievement of the student I will be supervising. |  |  |
| I agree to contribute to student assessment to inform decisions about prescribing suitability. |  |  |
| I will have sufficient opportunities to engage with the Practice Assessor and Academic Assessor to share relevant observations on the conduct, proficiency and achievement of the student I will be supervising. |  |  |
| I understand and value diversity, equality and inclusion. |  |  |
| I agree to appropriately raise and respond to student conduct and competency concerns during the prescribing course and will inform the University of Essex of any concerns. |  |  |

|  |  |
| --- | --- |
| **I confirm all the above standards can be met whilst the student undergoes practice supervision.** | |
| Practice Supervisor’s Full Name: |  |
| Signature *(wet / electronic signature):* |  |
| Date signed: |  |

* There may be exceptional occasions where it is not possible for the supervisor and assessor to be different people. Where there is no opportunity for different people to act as supervisor and assessor in the clinical area, the applicant must identify a prescriber who meets the requirements to be a Practice Assessor. This person will act as both supervisor and assessor. The Academic Assessor will require this person to attend extra collaborative meetings so that quality assurance and governance can be ensured. In such situations the PA, student and Academic Assessor will also meet at the end of the module to review placement competencies in relation to the Portfolio of Practice Evidence.

**9. DBS Check**

You are required to provide a copy of a current enhanced Disclosure and Barring Service (DBS) certificate, including barred list (adult & children). The DBS must be within the last 3 years and cover the period of training. Where a DBS expires during the period of training, a further enhanced DBS including barred list (adult & child) will need to be provided.

If you have signed up to the DBS Update Service, we require a copy of the enhanced DBS certificate, including barred list (adult & child) and evidence of your status for the update service.

A copy of your DBS certificate (pages 1 & 2) must be provided when you submit your application form.

Applications cannot be accepted without evidence of an enhanced DBS check. Where the issue date of the DBS is more than 3 years ago and/or does not cover the period of the course, you will be required to obtain an enhanced DBS including barred list before applying for the course.

**10. Processing Personal Data**

The University of Essex will hold and process your personal data for the purposes of maintaining your academic and related records. The information supplied on this form will be processed in line with the Data Protection Act 2018 and the UK General Data Protection Regulations. It will be kept secure and accurate and will only be disclosed in line with the law. Your attendance and Examination Board ratified module marks will be shared with your sponsoring Trust. If you do not wish this to happen, you are responsible for asking your line manager to communicate with the School to this effect. Further information on how the University of Essex processes your personal data is available on the [Privacy Policy for students](https://www.essex.ac.uk/student/my-essex/privacy-notice-students), which can be found on the University’s [Privacy Hub](https://www.essex.ac.uk/disclaimer/privacy-statements).

Please note that the information on this application form is required for registration purposes only.

**11. Applicant Self Declaration**

I confirm I meet the regulatory requirements and I am competent in clinical assessment, diagnosis, planning and evaluation of care.

I confirm I will have regular access to patients within my area of clinical practice in order to achieve the required 90 hours supervised practice.

I understand a learning outcome for this module is that learners undertake a comprehensive clinical history, including medications history and a review of current medications, including over the counter (OTC), complimentary & alternative therapies to inform diagnosis (RPS Competency 1, 5, 7).

I agree to undertake continuous professional development within own area of clinical practice.

I confirm I have completed this application form and have provided accurate information to the best of my knowledge and I understand that an incomplete application form cannot be accepted by the university**.**

|  |  |
| --- | --- |
| Applicants Full Name: |  |
| Signature: *(wet / electronic):* |  |
| Date signed: |  |

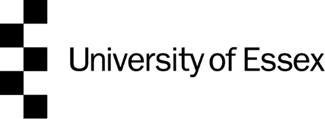
Thank you for completing this application form which must be completed in full and submitted to [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk).

***Before submitting your application form, please review the applicant checklist, section 12 (see below).***

**12. Applicant Check List**

Please check that all sections of the application form have been completed, dated and signed by all parties. Typed signatures cannot be accepted and application forms will be rejected where wet or electronic signatures are not provided.

|  |
| --- |
| **Applicant** - To complete: Page 1 and section 1 & section 2. Read section 9 (DBS), read section 10 (Processing Personal Data) and complete section 11 Applicant Self Declaration, which must be dated and signed. |
| **Applicant** – To provide a copy of a current enhanced DBS, including barred list (adult & child). Must be held within the last 3 years and cover the period of training. Where a DBS expires during the period of the course, a further enhanced DBS will need to be provided. A copy of pages 1 & 2 are required.  For those signed up to the DBS online update service. We require a copy of your enhanced DBS, including barred list (adult & child) and evidence of your status for the update service. |
| **Funding Authorisation (employer funded)** – Section 2a & 2b to be completed, dated and signed by the member of staff authorising the funding of the course fee. |
| **Line Manager** – To complete, date and sign sections 3 and 4.  For individuals who are self-funding / Non-NHS employed, the Practice Assessor is to complete, date and sign section 3 & section 4. |
| **Practice Assessor** – To complete section 5 and 6, date and sign.  *For applicants who are self-funding / Non-NHS employed, the Practice Assessor to also complete, date and sign sections 3 & 4.* |
| **Practice Supervisor** – To complete sections 7 and 8, date and sign. |
| ***Self-Funded applicants who are not employed within the NHS are to also provide the following documents:***   * Copy of the Contract / Honorary Contract of Employment with the organisation where the practice hours are to be completed. * 2 x Professional References, completed in full, dated and signed (see templates at the end of this application form) * Copy of the most recent CQC report for the practice area. Where an organisation is registered with the CQC but has not had an inspection and a report is not available, the organisation will not be suitable and an alternative practice area will need to be identified by the applicant. * Provide a copy of professional indemnity (insurance cover) that provides cover within the organisation where the practice hours are to be completed. The documentation should indicate those employed by the organisation are covered and preferably include the applicant’s name. |

**** Prescribing Programme Reference

**To be completed for Non-NHS Applicants only**

Thank you for agreeing to complete an application reference request for the prescribing programme at Essex University. Please complete all requested sections to the best of your knowledge and ability.

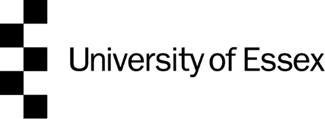
|  |  |  |
| --- | --- | --- |
| Name of Applicant: |  | |
| Name of Referee: |  | |
| Profession: |  | |
| Name & Address of Practice Setting: | |  |
| Position: |  | |
| Contact Number: |  | |
| Relationship to applicant: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| How many years / months have you known the applicant? | |  |  |
| In your opinion is the applicant of good character & health? | |  | |
| In your opinion does the applicant have the academic skills to undertake the programme at the level applied for? | |  | |
| Does the applicant uphold the professional standards of their regulatory body (NMC)? | |  | |
| Have you ever questioned the applicant’s ability to practice safely? | |  | |
| Are you aware of any previous or existing disciplinary actions that the applicant has been/is being investigated for? | |  | |
| Do you believe there is any reason why the above named applicant would not be suitable to undertake the prescribing course? | |  | |
| Please proved any additional comments or concerns: |  | | |

|  |  |
| --- | --- |
| Signature: *(wet / electronic):* |  |
| Date signed: |  |

Thank you for completing the above reference. The prescribing team may contact you should they have any further questions. Please email the reference directly to [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk).

Please note that the applicant’s application cannot be processed until this completed form has been received and processed by the prescribing programme team.

**** Prescribing Programme Reference

**To be completed for Non-NHS Applicants only**

Thank you for agreeing to complete an application reference request for the prescribing programme at Essex University. Please complete all requested sections to the best of your knowledge and ability.

|  |  |  |
| --- | --- | --- |
| Name of Applicant: |  | |
| Name of Referee: |  | |
| Profession: |  | |
| Name & Address of Practice Setting: | |  |
| Position: |  | |
| Contact Number: |  | |
| Relationship to applicant: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| How many years / months have you known the applicant? | |  |  |
| In your opinion is the applicant of good character & health? | |  | |
| In your opinion does the applicant have the academic skills to undertake the programme at the level applied for? | |  | |
| Does the applicant uphold the professional standards of their regulatory body (NMC)? | |  | |
| Have you ever questioned the applicant’s ability to practice safely? | |  | |
| Are you aware of any previous or existing disciplinary actions that the applicant has been/is being investigated for? | |  | |
| Do you believe there is any reason why the above named applicant would not be suitable to undertake the prescribing course? | |  | |
| Please proved any additional comments or concerns: |  | | |

|  |  |
| --- | --- |
| Signature: *(wet / electronic):* |  |
| Date signed: |  |

Thank you for completing the above reference. The prescribing team may contact you should they have any further questions. Please email the reference directly to [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk).

Please note that the applicant’s application cannot be processed until this completed form has been received and processed by the prescribing programme team.