# Application Pack 2022-23

**To apply:** Please complete this application pack **in addition to the online application form.** Please complete this application pack electronically and refer to the guidance about how to submit the form. Where signatures are required, you must scan the relevant page and e-mail together with this pack. Please ensure you complete and return all sections of this application pack. If any of the required information is missing, there will be a delay processing your application.

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| The DPP is required to submit **their CV** along with the application pack. The CV should provide evidence that they have:* active prescribing competence applicable to the area of practice in which you will be supervising the student
* appropriate patient facing clinical and diagnostic skills
* the ability to assess patient-facing clinical and diagnostic skills.

***Note: For non-medical prescribers, this should include when they gained their prescribing qualification and a copy of their IP qualification certificate.*** |

**Use of personal data:** We have only asked for information that is necessary and you can see our Privacy Notice on the university website: <https://www.ucl.ac.uk/legal-services/privacy/ucl-prospective-students-enquirers-and-applicants-privacy-notice>

**Closing date:** Please ensure that you submit this application pack prior to the closing date which can be found on our website. Applications received after the closing date will not be considered.

Personal Details

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| Name (as stated on the professional register) | Click here to enter text. |
| GPhC or PSNI registration number | Click here to enter text. |
| When did you register with the GPhC or PSNI? | Click here to enter text. |
| Have you previously been enrolled on an independent prescribing programme?*If you answer yes, please give further information* | No [ ] Yes [ ] Click here to enter text. |
| Are you currently enrolled on any other programmes of study at UCL or another institute (inc. CPPE pathway. Please tick yes if you have recently submitted your final assessments and are waiting for these to go through an exam board)? *If you answer yes, please give further information* | No [ ] Yes [ ] Click here to enter text. |
| Name and address of current employer | Click here to enter text. |
| Position with current employer  | Click here to enter text. |
| Please provide a brief description of your current role. *(In particular please highlight the patient facing aspects of this role and any involvement in the multi-disciplinary aspects of prescribing)* | Click here to enter text. |
| Date of employment with current employer | Click here to enter text. |

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| **Details of previous employment:***Please include your employment history in the last five years* |
| 1 | Name and address of previous employer | Click here to enter text. |
| Position with previous employer  | Click here to enter text. |
| Please provide a brief description of your previous role. *(In particular please highlight the patient facing aspects of this role and any involvement in the multi-disciplinary aspects of prescribing)* | Click here to enter text. |
| Dates of employment with previous employer | Click here to enter text. |
| 2 | Name and address of previous employer | Click here to enter text. |
| Position with previous employer  | Click here to enter text. |
| Please provide a brief description of your previous role. *(In particular please highlight the patient facing aspects of this role and any involvement in the multi-disciplinary aspects of prescribing)* | Click here to enter text. |
| Dates of employment with previous employer | Click here to enter text. |
| 3 | Name and address of previous employer | Click here to enter text. |
| Position with previous employer  | Click here to enter text. |
| Please provide a brief description of your previous role. *(In particular please highlight the patient facing aspects of this role and any involvement in the multi-disciplinary aspects of prescribing)* | Click here to enter text. |
| Dates of employment with previous employer | Click here to enter text. |

# Applicant Statement

**Name of Applicant:** Click here to enter text.

Please provide a statement to demonstrate how you meet the GPhC entry criteria described below and your reasons for wanting to undertake the Clinically Enhanced Pharmacist Independent Prescribing Course.

The GPhC Entry criteria are:

1. Be a pharmacist registered with the GPhC or the Pharmaceutical Society of Northern Ireland (PSNI)
2. Be in good standing with the GPhC and/or PSNI and any other healthcare regulator with which they are registered
3. Have at least two years’ appropriate patient-orientated experience post-registration in a relevant UK practice setting
4. Have identified an area of clinical or therapeutic practice in which to develop independent prescribing practice.
5. Have relevant clinical or therapeutic experience in their chosen area, which is suitable to act as the foundation of their prescribing practice training
6. Have a designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice and who meets the criteria for acting as a DPP

You may write as much as you need in the response to the questions in the boxes below, but you must provide evidence of meeting the criteria.

Applicants must have relevant clinical and/or therapeutic experience in their intended scope of practice, which is suitable to act as the foundation of their prescribing practice while training. Your applicant statement, combined with other application documents, may provide sufficient information, but where there are gaps, you should consider providing evidence that could enhance the admissions team’s understanding of your experience. Evidence could include:

* Evidence of academic credits for a module focused on your proposed scope of practice (e.g., a short-course module including learning outcomes focused on your proposed scope of practice).
* A PG Certificate or PG Diploma in Pharmacy Practice, or equivalent, which includes evidence of a focus during the learning on your proposed scope of practice
* Evidence of formal assessed learning in advanced history taking and/or diagnostics
* Submission of a professional portfolio of experiential learning showing proficiency in your intended scope of practice
* Attendance at continuing education events linked to your intended scope of practice
* Submission of CPD or revalidation records linked to your intended scope of practice
* Interview with a member of the admissions team

Please clearly label any additional attachments and refer to them in your statement. Additional attachments should be submitted in one file with your statement.

**Applicant Statement:**

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| Why I want to undertake the Clinically Enhanced Pharmacist Prescribing Course. *Please include the following:** *A reflection on what you personally want to achieve from the course*
* *How you plan to use your Independent Prescriber status once you have successfully completed the course.*
* *Details of any agreement you have with your employer/supporting organisation for how you will develop your practice as an independent prescriber.*

Click here to enter text. |

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| Please define the area of clinical or therapeutic practice in which you intend to develop your independent prescribing practice. Remember that you will initially be a NOVICE prescriber. It may not be appropriate to align your scope of prescribing practice to the scope of your practice as an experienced pharmacist. Once you have gained experience as a prescriber in your initial scope of practice, you will be able to develop your competence to prescribe in other areas of practice. Please ensure you describe a defined scope of practice e.g. ‘Hypertension in adults aged 50-75 years excluding pregnant women’.Please also describe the setting in which you plan to work as a prescriber, and the multidisciplinary team in which you will be working as a Trainee Independent Prescriber.Defined scope of clinical practice: Click here to enter text.Setting: Click here to enter text.Multidisciplinary team: Click here to enter text. |
| Evidence of at least two years’ appropriate patient-orientated experience post-registration in a relevant UK practice setting.*Please provide a description of your experience and include the following:** *The patient facing aspects of your experience, including consultations*
* *How this experience has prepared you to train to be a prescriber*
* *Your involvement in the multi-disciplinary aspects of prescribing*

Click here to enter text. |
| Evidence of relevant clinical or therapeutic experience in chosen area of practice, which is suitable to act as the foundation of my prescribing practice training*Please provide a description of your evidence. You may wish to include the following:* * *What experience do you have in your intended scope of practice?*
* *What prescribing decision making experience do you have in your intended scope of practice?*
* *What role have you had in clinical interventions and medicines optimisation in your scope that has prepared you for this prescribing programme?*
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| *Provide a reflection on* ***TWO*** *of the following professional experiences you have so far encountered* ***related to your intended scope of practice****. Remember these must be related to your intended scope of practice:** *Patient facing experience*
* *Clinical prescribing experience*
* *Participation in clinical interventions and medicines optimisation*
* *Experience in multi-disciplinary aspects of prescribing*

*Please note, the reflection should be no more than 700 words for* ***both*** *examples. The reflection should detail:* * *Your level of participation in the experience (i.e. were you a passive observer or actively participating)*
* *What you learnt from the experience*
* *What learning needs you identified and your subsequent action plan to meet those learning needs.*

*You may wish to use your GPhC submitted records (up to 12 months old) to support these reflections.*Click here to enter text. |

# Learning Needs Analysis

**Name of Applicant:** Click here to enter text.

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| A pharmacist independent prescriber must be able **make, confirm or understand**, the working or final diagnosis by systematically considering the various possibilities (differential diagnosis). By the end of the course your DPP must provide confirmation that you are clinically competent in the area in which you intend to prescribe when you qualify. This includes the clinical assessment of patient and the ability to use basic diagnostic aids and make an assessment of the patient’s general health. Please note that you are applying for a Clinically Enhanced Independent Prescribing Course and so you will cover basic assessment of all the body systems, however, there may be some more specific assessment skills that are required for your area of clinical practice. Discuss with you DPP the specific assessment skills for your area of clinical practice that you will need to develop and complete the form below. Please describe the specific assessment skills related to your chosen area of clinical practice, any specific diagnostic equipment you will need to be able to use and how you plan to achieve competence in these skills under the supervision of your DPP.*Clinical and diagnostic skills specific to chosen area of clinical practice:*  Click here to enter text.*Diagnostic aids I will need to be able to use related to my chosen area of clinical practice:*Click here to enter text.*How I plan to develop my competence in clinical assessment for my chosen area of clinical practice. (You will need to discuss this with your DPP. Your plan might include, for example, observing practitioners who are specialists in the clinical area in which you intend to prescribe, practising clinical assessment skills on colleagues and friends and family, practising on patients under supervision):* Click here to enter text. |

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| *Please describe how your will develop your own networks for support, reflection and learning, including prescribers from other professions and the multidisciplinary team:*Click here to enter text. |

# Declaration from Designated Prescribing Practitioner

**DPP:** Please provide the details requested on this page, complete the declaration on the following page and sign in the appropriate place in section 9.

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| **Background experience** |
| Applicant Name: | Click here to enter text. |
| DPP Name: | Click here to enter text. |
| Healthcare profession and registration number: | Click here to enter text. |
| Employing organisation: | Click here to enter text. |
| Job title: | Click here to enter text. |

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| **Evidence that I can demonstrate the Competencies within The Competency Framework for Designated Prescribing Practitioners** |
|  | **Yes** | **No** |
| I have previously undertaken the role of Designated Medical Practitioner or Designated Prescribing Practitioner for a prescribing trainee | [ ]  | [ ]  |
| I have experience of teaching and/or supervising workplace-based learning | [ ]  | [ ]  |
| I have experience of conducting assessments of trainees in clinical practice | [ ]  | [ ]  |
| Please chose one of these options (See Figure 1 in DPP Information Sheet) | I have annotation as a GMC trainer | [ ]  | [ ]  |
| I have completed STP training, DPP training at another University or eLFH Educator Training Resources and will provide the Certificate of Completion | [ ]  | [ ]  |
| I will provide evidence of completion of other formal training in Workplace Based Learning | [ ]  | [ ]  |
| I will provide evidence of my relevant experience in workplace-based training |  |  |
| Please provide details of your previous experience as a Designated Prescribing Practitioner. *Please include which healthcare professions you have supported*Click here to enter text. |

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| **Training Plan** |
| Please provide details of the mechanisms you have in place to support the trainee in the following categories:1) Induction 2) Effective supervision 3) An appropriate and realistic workload 4) Personal and academic support5) Access to resourcesClick here to enter text. |

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| **Governance** |
| Whilst supporting this applicant, how many other prescribing students will you be supporting as DPP? (Please include all prescribing students you are supporting, including those at other institutions.)Click here to enter text. |

**Name of applicant:** Click here to enter text.

**DPP:** Please complete the following declaration and return to the applicant to submit to the University.

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|  | **YES** | **NO** |
| Personal Characteristics | I can demonstrate clinical leadership through my practice | [ ]  | [ ]  |
|  | I create a positive learning culture through my practice | [ ]  | [ ]  |
|  | I understand my role as a DPP | [ ]  | [ ]  |
|  | I regularly reflect on and audit my prescribing practice to identify my development needs, including recording continuing professional development on their knowledge and skills for my role as a DPP | [ ]  | [ ]  |
| Professional Skills and  | I am an experienced prescriber in a patient-facing role with at least three years recent prescribing experience  | [ ]  | [ ]  |
|  | I am an active prescriber in a patient-facing role relevant to the applicant’s scope of practice | [ ]  | [ ]  |
|  | I have up to date patient-facing clinical and diagnostic skills relevant for the applicant’s scope of practice | [ ]  | [ ]  |
|  | I confirm I meet all the competencies in the Competency Framework for All Prescribers | [ ]  | [ ]  |
| Working in partnership | I agree to supervise, support and assess the applicant during their clinical placement, for a minimum of 90 hours | [ ]  | [ ]  |
|  | I agree to directly supervise the applicant for 50 % of their Learning in Practice time  | [ ]  | [ ]  |
|  | I will work with the applicant to establish their baseline knowledge and jointly create a development plan for meeting the learning outcomes | [ ]  | [ ]  |
|  | I agree to provide the applicant with opportunities to develop their competence in prescribing | [ ]  | [ ]  |
|  | I will advocate and facilitate a multidisciplinary approach to training | [ ]  | [ ]  |
| Prioritising Patient Care | I will act in the best interest of patient and public safety when making decisions on the applicant’s competence | [ ]  | [ ]  |
|  | I will ensure that the applicant is supervised by an appropriately trained supervisor at all times | [ ]  | [ ]  |
| Learning Environment | I have negotiated sufficient time to support the applicant in their period of Learning in Practice | [ ]  | [ ]  |
|  | I encourage an environment that promotes equality, inclusivity and diversity | [ ]  | [ ]  |
| Governance | I have been provided with information previously, or by the applicant, about this role |[ ] [ ]
|  | I have the support of my employing organisation or GP practice to act as the DPP for this applicant | [ ]  | [ ]  |
|  | I do not have a close personal relationship with the applicant.*A professional relationship must exist between the applicant and the DPP and they should not be a close family member.* | [ ]  | [ ]  |
|  | I understand that this is a clinically enhanced independent prescribing course and that I will be required to support the applicant to develop clinical assessment skills in addition those requirements stipulated by the GPhC (Please see the DPP information pack on the website for details of the course) | [ ]  | [ ]  |
|  | I agree to complete any workplace-based learning training that may be required before the applicant starts the course | [ ]  | [ ]  |
|  | I agree to undertake the University Induction for this Course | [ ]  | [ ]  |
|  | I am in good standing with my professional body and do not have any restrictions on my practice | [ ]  | [ ]  |

# Employer/sponsor/supporting organisation Reference

**Employer/sponsor/supporting organisation:** Please supply a written reference for the applicant in support of their application to study on the Clinically Enhanced Pharmacist Independent Prescribing Couse. The reference should include the following:

* The suitability of the applicant to train as a prescriber including:
	+ Their patient facing work experience
	+ Their involvement in the multi-disciplinary aspects of prescribing
	+ Their clinical or therapeutic experience in their chosen area of prescribing practice

Please provide the reference in the form of a letter on appropriately headed paper. Please also ensure that the reference is signed and that the particulars of the referee are clearly provided.

# Declaration from organisation providing learning in practice

**Organisation supporting learning in practice time:** Please complete the following declaration and sign the document in Section 9 before returning to the applicant.

The following person should complete this form as a representative from the organisation supporting the Learning in Practice time:

* NMP Lead (Mandatory for NHS Trusts) or lead for education and training where the NMP lead role does not exist (*this should not be the proposed DPP*)
* In a GP practice setting this could be the practice manager

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| **Criteria** | **Yes** | **No** |
| 1 | I have considered and support the above application. In my opinion the above applicant is a suitable candidate to undertake the prescribing programme, including competence, experience and academic ability |[ ] [ ]
| 2 | I can confirm that the trainee independent prescriber will be supported and that sufficient time has been organised in order for them to complete all elements of the course. This includes attendance at the required study days and a minimum of 90 hours of learning in practice time.  |[ ] [ ]
| 3 | There is sufficient capacity and infrastructure to appropriately support the applicant in their studies in this organisation |[ ] [ ]
| 4 | If the applicant is not an employee, they will be provided with an induction to the organisation prior to starting their Learning in Practice time |[ ] [ ]
| 5 | The organisation has appropriate indemnity insurance to enable to applicant to train as a prescriber |[ ] [ ]

# Details of Funding Source

**Name of applicant:** Click here to enter text.

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|  | **Tick if Correct** |
| I have secured funding for the course fees from my employerIf you are being funded by an employer/sponsor, please complete a copy of the Sponsorship letter (found at the end of this document) to be passed on to the UCL Student Fees department if your application is successful to ensure your sponsor is invoiced correctly. | [ ]  |
| I am studying this course as the FS2 option for the UCL Diploma in General Pharmacy Practice, and my fees will be paid for by my training centre |[ ]
| I intend to pay my own course fees | [ ]  |

# Applicant Declaration

**Name of Applicant:** Click here to enter text.

|  |  |
| --- | --- |
| **Please tick the box to confirm the statements below** | **Tick if Correct** |
| I am currently registered with the GPhC / PSNI |[ ]
| I am not subject to any current or ongoing fitness to practice investigations by the GPhC/PSNI |[ ]
| I have at least two years of appropriate patient orientated experience in a hospital, community or primary care setting after my pre-registration year |[ ]
| In accordance with the GPhC “Standards for Pharmacy Professionals” I agree that I must notify the UCL Academic Lead for the course if there are any circumstances relating to my fitness to practice, including any pending, current or past investigations, or criminal convictions |[ ]
| I acknowledge that as part of my enrolment on this course, UCL may be required to contact the GPhC, my employer and/or my funding body for this programme in relation to any false declarations made on my application, and, if my application is successful, my attendance, performance and behaviour on the course |[ ]
| I understand that if I have not uploaded ALL the documentation required by UCL my application will not be accepted |[ ]
| I have NOT previously been enrolled on a course at another institution leading to a Practice Certificate in independent Prescribing |[ ]
| I have the support of my employer/sponsor or supporting organisation to undertake the Clinically Enhanced Pharmacist Independent Prescribing Course |[ ]
| I have discussed my Learning Needs Analysis with my Designated Prescribing Practitioner | [ ]  |
| I have an agreement with a Designated Prescribing Practitioner to supervise my time in practice – representing a minimum of 90 hours  |[ ]
| I do not manage/supervise or have a close personal relationship with my Designated Prescribing Practitioner*A professional relationship must exist between the applicant and the DPP they should not be a close family member or someone that you supervise or manage*. |[ ]
| I confirm that I have read the dates of the intended study days on the UCL SOP website and I am able to attend on all of the dates. I understand that attendance on all the study days is a requirement of the programme. |[ ]
| I understand that this is a Clinically Enhanced Independent Prescribing Course and that I will be required to develop clinical assessment skills in addition those requirements stipulated by the GPhC |[ ]
| I confirm that the information I have provided above in support of my application to the Clinically Enhanced Pharmacist Independent Prescribing Course is correct. |[ ]

# DPP, supporting organisation and Applicant signatures

*“I have read the relevant requirements and certify that these details supplied in this application are correct”*

8.1 DPP

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| **DPP Signature:**  | **Date:** Click here to enter text. |
| **Professional qualifications and registration number: Click here to enter text.** |
| **DPP Name (Please print):** Click here to enter text. |
| **Contact address: Click here to enter text.** |
| **Contact Telephone number: Click here to enter text.** |
| **E-mail address: Click here to enter text.** |

8.2 Organisation supporting learning in practice time

|  |  |
| --- | --- |
| **Signature:** | **Date:** Click here to enter text. |
| **Name:** Click here to enter text. |
| **Position within supporting organisation:** Click here to enter text. |
| **Name of organisation:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **Contact telephone number:** Click here to enter text. |
| **E-mail address:** Click here to enter text. |

8.3 APPLICANT

|  |  |
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| **Applicant Signature:**  | **Date:** Click here to enter text. |

**APPENDIX 1: SPONSORSHIP LETTER TEMPLATE**

***(To be completed if fees are being covered by a sponsor only)***

Sponsor address

Tel:

Email:

Web address:

Date:

UCL Student Fees Office

Room G19, South Wing

UCL

Gower St.

London WC1E 6BT

Dear Sir or Madam,

**CONFIRMATION OF SPONSORSHIP FOR CERTIFICATE IN GENERAL PHARMACY PRACTICE (PRESCRIBING)**

This is to confirm that [SPONSOR ORGANISATION NAME] accepts responsibility for the full payment of tuition fees from [date] for the student named below.

**Name:**

Please address invoices to:

[Invoice name and address]

Any questions relating to this sponsorship should be directed to xxx (phone no.) or xxx (phone no.**)**

Thank you.

EPD name

Title

Trust

Finance department contact email address: