# Application Details

**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.

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

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# Personal Details

|  |  |
| --- | --- |
| 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. |
| 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. |

|  |  |  |
| --- | --- | --- |
| **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. You must be a registered pharmacist with the GPhC or the Pharmaceutical Society of Northern Ireland (PSNI)
2. You must have at least two years appropriate patient-orientated experience in a UK hospital, community or primary care setting following your pre-registration year
3. You must have identified an area of clinical practice in which to develop your prescribing skills and have up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to your intended area of prescribing practice
4. You must demonstrate how you reflect on your own performance and take responsibility for your own CPD.

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. In addition to your own statement you must provide:

* A written reference from your current employer (see section 5 below).

In addition, where possible, please provide course certificates from courses you have completed in your intended area of clinical practice for prescribing. Please note that we do not need to see certificates from every course you have ever completed. Please only send in certificates of courses that are relevant to your intended area of clinical practice for prescribing.

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:**

|  |
| --- |
| *Why I want to undertake the Clinically Enhanced Pharmacist Prescribing Course.*  *(In particular please provide a reflection on what you personally want to achieve from the course, and how you plan to use your Independent Prescriber status once you have successfully completed the course. Please provide 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. |

|  |
| --- |
| *Evidence that I have at least two years appropriate patient-orientated experience in a UK hospital, community or primary care setting following my pre-registration year:*  *(In particular please highlight the patient facing aspects of your experience and any involvement in the multi-disciplinary aspects of prescribing)*  Click here to enter text. |
| Please define the area of clinical practice in which you intend to develop your prescribing skills over the course. 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.  Defined scope of clinical practice: Click here to enter text.  Setting: Click here to enter text.  Multidisciplinary team: Click here to enter text. |

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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****.*  *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 an 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 12months old) to support these reflections.*  *Chose two of the following professional experiences for your reflections. 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*   Click here to enter text. |

# Learning Needs Analysis

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

|  |
| --- |
| 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 DMP 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 DMP 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 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 DMP.  *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 DMP. 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. |

|  |
| --- |
| *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 Medical Practitioner

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

**DMP:** Please provide the details requested on this page and complete and sign the declaration on the following page.

|  |  |
| --- | --- |
| **Background experience** | |
| Employing organisation: | Click here to enter text. |
| Job title: | Click here to enter text. |
| Please provide details of your previous experience as a Designated Medical Practitioner.  *Please include which healthcare professionals you have supported and the Universities where they studied.* | Click here to enter text. |
| Please provide details of any training you have undertaken in order to carry our your role as a Designated Medical Practitioner | Click here to enter text. |
| Please indicate your current experience of supervision, support and assessment of trainees in practice (please tick all those which apply). | GP Trainees  Medical Students  Junior Doctors  Nurses  Pharmacists  Other Healthcare professional (Please state) |
| Please provide details of how you will support the trainee in the following categories: 1) Induction  2) Effective supervision  3) An appropriate and realistic workload  4) Personal and academic support 5) Access to resources | Click here to enter text. |
| Please describe the procedures that are in place should the trainee need to raise a concern about: 1) The practice of a registered prescribing professional 2) The practice of any other healthcare professional 3) The level of support they are receiving |  |

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| ***Department of Health criteria for the supervision of the Learning in Practice time for Independent Prescribing Courses*** | | **YES** | **NO** |
| 1 | I am a registered medical practitioner with at least three years medical, treatment and prescribing responsibility for a group of patients/clients in relation to the clinical condition(s) for which the trainee independent prescriber is going to use their independent prescribing skills |  |  |
| 2 | I am **EITHER:** within a GP practice and either vocationally trained or in possession of a certificate of equivalent experience from the Joint Committee for Postgraduate Training in General Practice  **OR**  A specialist registrar, clinical assistant or a consultant within a NHS trust or other NHS employer |  |  |
|  |  |
| 3 | I have some experience and training in teaching and/or supervision in practice |  |  |
| 4 | I have the support of my employing organisation or GP practice to act as the DMP who will provide supervision, support and opportunities to develop the trainee independent prescriber’s competence in prescribing practice |  |  |
| **Additional Criteria** | |  |  |
| 1 | I agree to provide the applicant with opportunities to develop their competence in prescribing |  |  |
| I agree to supervise, support and assess the applicant during their clinical placement, for a minimum of 90 hours |  |  |
| 2 | I am familiar with the GPhC requirements of the Independent Prescribing programme and the need for the trainee independent prescriber to achieve the learning outcomes |  |  |
| 3 | 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 DMP information pack on the website for details of the course) |  |  |
| 4 | I have active prescribing competence applicable to the clinical areas in which I will be supervising |  |  |
| 5 | I have appropriate patient facing clinical and diagnostic skills |  |  |
| 6 | I have the ability to assess patient-facing clinical and diagnostic skills |  |  |
| 7 | I am not subject to any current or ongoing fitness to practice investigations by the GMC |  |  |

# Declaration from Employer/Sponsor/Supporting Organisation

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

**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
  + Assurance of their pharmaceutical skills, knowledge and experience in their intended clinical area of practice

You may include your reference in the box below, or alternatively, a letter on appropriately headed paper will be accepted. Please also ensure that you complete and sign the declaration on the next page.

|  |
| --- |
| **Employer/sponsor/supporting organisation:** Click here to enter text.  Please include your reference here.  Click here to enter text. |

**Employer/sponsor/supporting organisation:** Please complete the following declaration and return to the applicant together with your reference for them to submit to the University.

|  |  |  |  |
| --- | --- | --- | --- |
| **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. |  |  |
| 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 | I can confirm that the applicant has at least two years of appropriate patient orientated experience in a hospital, community or primary care setting after their pre-registration year. |  |  |
| 4 | I can confirm that the applicant has up-to-date clinical, pharmacology and pharmaceutical knowledge relevant to this identified area of prescribing practice. |  |  |
| 5 | I can confirm that, to my knowledge, the applicant has not undertaken an Independent Prescribing course, or part thereof, via another Higher Education provider. |  |  |

# Details of Funding Source

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

|  |  |
| --- | --- |
|  | **Tick if Correct** |
| I have secured funding for the course fees from my employer  If 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 |  |
| I have up-to-date clinical, pharmacology and pharmaceutical knowledge relevant to the identified area of prescribing practice |  |
| I reflect on my own performance and take responsibility for my own CPD. |  |
| 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 the roles and responsibilities of the DMP with my nominated DMP and I have provided them with the UCL DMP FAQs |  |
| I have an agreement with a Designated Medical 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 Medical Practitioner  *A professional relationship must exist between the applicant and the DMP 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 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.  *Please note that UCL would be obliged to pass on to the University Fitness to Practice committee the names of any applicants who have deliberately falsified information to support their application to the course.* |  |

# DMP, Employer and Applicant Declarations and signatures

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

8.1 DMP

|  |  |
| --- | --- |
| **DMP Signature:** | **Date:** Click here to enter text. |
| **Professional qualifications and registration number: Click here to enter text.** | |
| **DMP 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 EMPLOYER

|  |  |
| --- | --- |
| **Signature of employer:** | **Date:** Click here to enter text. |
| **Name of employer:** Click here to enter text. | |
| **Position within employing 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

|  |  |
| --- | --- |
| **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: