

 **SCHOOL OF NURSING**

APPLICATION FORM – INDEPENDENT PRESCRIBING

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| PRESCRIBING FOR HEALTHCARE PROFESSIONALS   | COMMUNITY NURSE PRESCRIBING   | PRESCRIBING FOR PHARMACISTS  |

 **(please tick the appropriate box above )**

Please complete in black ink in block letters in the spaces provided. When completed please scan and e-mail it to:

admissions-health@bradford.ac.uk

**PART A: TO BE COMPLETED BY THE APPLICANT**

 **IF YOU ARE A CURRENT STUDENT PLEASE PROVIDE YOUR UoB Number:**

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| Do you wish to study at *(delete as appropriate*)Level 6 (undergraduate) or Masters level 7 (postgraduate) |
| 1. Last Name:
 | 2. Title: Miss/Mr/Mrs/Ms/Other:  |
| 3. Forenames in full: | 4. Previous Last Name (*if applicable)* |
| Nationality: | Country of Birth: | Country of Residence: |
| 5. NMC/GPhC /PSNI/HCPC registration or PIN no. (required): | 6. Date of Birth: |
| 7. Occupation (**please tick the appropriate box)**Midwife  Nurse  Paramedic  Pharmacist  Physiotherapist  Podiatrist  Radiographer  |
| 8. Have you undertaken/started a prescribing module at any other Higher Education Institution? Please give details: |
| 9. Home or Permanent Address:Daytime Telephone Number: E- mail Address:Daytime Telephone Number: E- mail Address: |

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| 10. Address for correspondence if different from the above: |
| 11. Work Address:Telephone Number/Extension: Contact Person for Messages: |
| 12. Qualifications  Qualification Institution Date Studied |
| 13. Employment1. Length of time employed in the profession since qualification:
2. Clinical area within which you will prescribe and length of time you have worked in this clinical area:
 |
| 14. Designated Medical Practitioner/Mentor contact name, address and telephone number Telephone No:  E-mail: Date of last Care Quality Commission inspection of this service: Were all standards met? |

15. Manager/Employer support **(If you are self-employed please tick box 4 and sign below making it clear you are self-employed**. **You will also need to send a copy of your DBS form with your application)**

Please indicate your agreement (tick box and sign)

1. the student will be enabled to attend study days, to undertake directed learning as required and to undertake prescribing practice days 🞎
2. That the student is competent in their own area of practice 🞎
3. That a criminal convictions check (Disclosure and Barring Service) has

 been completed in the last 3 years and has been seen by the Manager. 🞎

1. I am Self Employed and enclose a copy of my DBS certificate 🞎

 Employers - please also indicate other health care professional students normally supported in

 this practice setting:

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| --- | --- | --- |
| **Health/social care****professional students** | **Number** | **Facilitator** |
| Medical students |  |  |
| NursesPre-registration Post-egistration |  |  |
| Other students (please list): |  |  |

**Applications received without the support of the manager will not be progressed**.

Manager's Name *(block letters):*

Title:

Contact telephone number:

Managers Signature:

Please note that there should be a need for the applicant to prescribe in their role and once qualified their job description must be amended

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|  16. NHS Trusts/Organisations will have a named non-medical prescribing lead. If your organisation does not have a non-medical prescribing lead please complete the Clinical  Placement Audit Form which can be found here: <https://www.bradford.ac.uk/course-application-forms/SSPRD-funding-form.docx> The course leader may contact your manager. Non-Medical Prescribing Lead: Name, employer and address.e-mail address:Telephone number:I support this application for training as a non - medical prescriber and approve the nominated DMP. Non-medical prescribing lead signature: Date: |
| 17. Criminal conviction check: * Applicants for the course should be aware that your employer will be asked to confirm that you have had a criminal convictions check. (Courses in health are exempt from the Rehabilitation of Offenders Act 1974).
* Independent practitioners must supply a recent Disclosure and Barring Service enhanced disclosure document. The Faculty of Health Studies may be able to facilitate independent practitioners’ application for a disclosure document. If you have been convicted of a relevant criminal offence since the last check you must tell us.

 Applicant self-declaration (please tick): I do not have any criminal convictions/cautions/bind –overs 🞎 I have not had a criminal conviction since my last criminal conviction check 🞎 I have a criminal conviction 🞎 |
| 18. **Please attach a Curriculum Vitae** (and provide a supporting statement below) with this application form that covers the following areas: - Name, job title, place of work, professional qualifications, academic qualifications including level, dates, work experience, study interests and professional activities, continuous professional development arrangements and how this course will help you develop prescribing practice? |

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| Supporting Statement: |

**Applicant Signature (required):**

 Date:

Approved by Course leader:

Name:

 Signature:



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PART B: TO BE COMPLETED BY DESIGNATED MEDICAL PRACTITIONER/ MENTOR

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| NAME: |
| Work–based address:Postcode: Tel no: | Preferred contact arrangements: Telephone:E – mail:Secretary/admin: |
| Employer: |
| DEPARTMENT OF HEALTH –DESIGNATED MEDICAL PRACTITIONER/MENTOR CRITERIAAre you a General Practitioner and do you hold a vocational Training Certificate or an equivalent that is recognised by the joint committee for Post Graduate training in General Practice or an equivalent exemption certificate? Have you had 3 years recent prescribing experience in a relevant field of practice?YES 🞎 NO 🞎ORAre you a specialist registrar, Clinical assistant or consultant within an NHS trust or other NHS employer with 3 years recent prescribing experience in a relevant field of practice?YES 🞎 NO 🞎ORAre you a practicing community practitioner nurse prescriber with prescribing experience in a relevant field of practice? YES 🞎 NO 🞎 |
|  |
| Do you have the support of the employing organisation or GP practice to act as a designated medical practitioner/mentor who will provide supervision, support and opportunity to develop/acquire competence in prescribing practice?YES 🞎 NO 🞎 Have experience in training, teaching and/or supervising in practice?YES 🞎 NO 🞎Please offer details below: |

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| --- |
| QUALIFICATIONS |
| ProfessionalDateGMC Registration Number: | AcademicDate |
| Teaching/Mentor Qualification(s) |
| Recent professional development e.g. conferences/study days/learning units to support prescribing role. |
| Have you been a mentor/DMP for a prescribing student before?YES 🞎 NO 🞎 |

Signature………………………………………………………

Date……………………………………………………………..

**Checklist for Application**

In order for us to Process your Application please make sure you have completed all sections of the form and included all documents. Only fully completed applications will be considered. Incomplete application forms will not be considered and applicants will need to re-submit their application when they are completed in full.

All applications received will be considered by the programme lead once the submission deadline has passed.

 Curriculum Vitae

Completed Audit form (available on website), if your organisation does NOT have a Non - Medical Prescribing Lead.

Copy of DBS certificate if your line manager has not signed to say they have seen one.

Copy of highest qualification.

 Are sections 14, 15, 16 and Part B of the application fully completed and signed?