

**School of Health and Social Care****HS637 Practice Certificate in Supplementary and Independent Prescribing for Allied Health Professionals**

Please type or use block capitals to complete **ALL** sections of this form

**Campus/Site:**

**Start Date:**

**Please select Level - Level 6 or Level 7 (*delete as appropriate*)**

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**1. Personal Details**

Surname Title Mr/Mrs/Miss/Ms (*delete as appropriate*)

First names (in full) Male/Female (*delete as appropriate*)

Maiden name (*if applicable*)

Home address

Post code

Telephone number Email address

**\*Employer:**

**Employer Address:**

Date of birth \*NMC/HCPC PIN (*if applicable*)

Country of birth Nationality (as on passport)

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**2. Proposed source of funding**

Health Education (East of England) ☐

Employer Funded ☐

Self-Funded ☐

Other (please specify)

Has this funding been approved? Yes ☐ No ☐

If you have confirmed funding through your workplace, please complete this section:

Name and position of authorising member of staff (print name):

Signature of authorising member of staff: ..... Date: .....

If you require an invoice for your fees to be sent to your employer, please give contact details and address below:

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

### 3. Academic and professional qualifications (if applicable)

Date of award	Awarding Institution	Course Title/Subject	Result

Have you previously studied at the University of Essex? Yes ☐ No ☐

### 4. Employment History (past and current)

Dates of employment	Place of employment	Job Title

Clinical profession		Please give job title
Nursing	<input type="checkbox"/>	
Midwife	<input type="checkbox"/>	
Allied Health Professional	<input type="checkbox"/>	
Health Care Scientist	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
Unknown	<input type="checkbox"/>	

#### For Office use (NMC/HCPC recordable modules only)

First level/Second Level Registration  
(Delete as appropriate for NMC PIN)

Registration confirmed by: .....

Approved by Module/Programme Lead

.....Date.....

Any other comments relevant to this application?

## 5. Identification

	Yes	No
Has at least 3 years relevant post-registration experience and deemed competent by employer*		
Has the last year been spent working in the clinical field in which you intend to prescribe?		
Has undertaken a health status check for current employment (If no please attach evidence of health status from GP)		
Is willing to undertake the training set out in the course handbook		
Has identified a <b>service need</b> in conjunction with employer requiring the candidate to undertake independent/supplementary prescribing training?		
Has employer given commitment to : - Candidate's attendance on the programme?		
Has employer given commitment to: - Provision of continuing professional development?		
Has employer given commitment to: - Provision of a Designated Medical Prescriber as Mentor?		
Is the candidate currently enrolled on or successfully completed a recognised credit bearing consultation/assessment /diagnostics skills module or a 3/5 day condensed consultation and assessment non-credited course. (Please provide course title, start date of course and education provider below) ..... ..... <b>OR:</b> Has the candidate demonstrated within their knowledge and skills framework that they are regularly undertaking specialist assessments within their role (line manager to complete <b>page 6</b> )		
Has employer given commitment to: - Access to a prescribing budget and other necessary arrangements for prescribing practice?		
Have you applied and commenced a programme of prescribing preparation previously? ( If so please list reason for non completion below) .....		

\* Part-time workers must have practiced for a sufficient period in the period preceding application to the programme in the clinical field in which you intend to prescribe to be deemed competent by their employer.

## 6. Rationale

Give brief detail of how the present responsibilities of the post holder fit with opportunities to potentially prescribe on a regular basis:
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NB. Adequate opportunity to prescribe is essential to ensure maintenance of competency and value for money in terms of training costs

## 7. Mentorship Agreement Form

DMP agrees to be a mentor to a nurse or AHP undertaking the course.
DMP has been working as registered medical practitioner who has had at least 3 years recent medical, treatment & prescribing responsibility for a group of patients/clients in the relevant field of practice.
DMP works as a GP within a practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the Joint Committee for Post-graduate Training in General Practice Certificate <b>OR</b> as a Specialist Registrar, Clinical Assistant or Consultant within an NHS Trust or other NHS employer.
DMP has some experience or training in teaching and/or supervising in practice
DMP agrees to mentor no more than 2 students at any one time
DMP has the approval of the employer to undertake the mentoring role?
DMP agrees to undertake a short preparation for the mentoring role if they have not been a DMP for a nurse/AHP independent /supplementary prescriber in the past.

The designated mentor does have a crucial role in educating and assessing non-medical prescribers.

This includes:

- Establishing a learning contract with the student
- Facilitating learning through critical thinking and reflection
- Providing dedicated time and opportunities for the student to observe how the mentor conducts a consultation or interviews the patient/carer and develops a management plan
- Allowing time for the student to carry out consultations and suggest clinical management plans and prescribing options which are discussed with mentor
- Allowing for the development and integration of theory and practice
- Giving opportunities for in-depth discussion and analysis of clinical management plans using random case studies where patient care and prescribing behaviours can be discussed further
- Assessing and verifying that by the end of course the student is competent to take on the prescribing role

Source: Training Non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner. National Prescribing Centre, NHS, Feb 2005.

**Section A – To be completed by the student** (Please print)

Name of Student:

Work Contact Details (Address, Tel. No., e-mail and fax if available)

**Section B - To be completed by the designated medical practitioner** (Please print)

Name of Designated Medical Practitioner:

Designation and Professional Qualifications:

Work Contact Details (Address, Tel. No., e-mail and fax if available):

I have discussed the designated medical practitioner role with the above student and have the support of my employer to provide 12 days practice based training. I agree to undertake the role and to access the preparation provided.

Signature.....Date.....

**Please delete as appropriate:** My place of work does/does not have an equal opportunities/anti-discriminatory policy relevant to students undertaking practice based training.

Include any other information relevant to this application:

**Data Protection Act 1998**

The University of Essex has a notification under the Data Protection Act 1998 to enable it to hold and process personal data about its students for the purposes of maintaining their academic and related records. The information supplied on this form will be held under the terms of the Act; it will be kept secure and accurate and will only be disclosed to people who have a need to know in accordance with the Act. *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.*

**Please note that the information on this application form is required for registration purposes only. Your email address and level of study will be provided to the NMC on completion of the course for registration purposes.**

Signature of candidate.....

Signature of Line Manager.....

DBS complete and verified by Employer	Yes/No
I confirm that this applicant is of good health and character	Yes/No

Signature of Education Liaison Manager.....

Print Name .....

For applicants funded from NHS Contracts, please return this to your Education Liaison Manager (who will authorise it and return it to HSC on your behalf); for all other applicants, please sign and confirm payment details, then return the form to the HSC Contracts Administrator (SHSC, University of Essex, Wivenhoe Park, Colchester, Essex CO4 3SQ / [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk)).

**\*Approved by Module Lead – Signature:** .....**Date:** .....

**Supplementary Evidence:****Employer confirmation of ability to diagnose in candidate's area of speciality**

Please complete the following information in block capitals:

**Applicant Name:****Applicant Job Title:****Area of Speciality:****Name of Line Manager:****Name of Employing Organisation:**

On behalf of the employer I confirm that the above named applicant has been assessed as competent to take a history, undertake a clinical assessment, and diagnose. I am aware that registrants should not be put forward for the Non Medical Prescribing course if they have not demonstrated the ability to diagnose in their area of speciality\*.

**Signature of Line Manager:**.....**Date:**.....

\*For Nurses - NMC guidance states "it should be possible to identify whether a registrant has these skills through Continuing Professional Development (CPD) reviews within the work place setting"

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### Equal Opportunities

This form will be detached.

Please complete and return it with your application.

The information you provide will be held on database and will only be used for statistical analysis by HESA and certain other bodies that deal with the funding of education.

Thank you.

### Personal Details

Last name  Title (eg. Mr, Mrs, Ms)

First name(s) (for official purposes)  Preferred first name

Date of birth

**Gender** \*delete as necessary  MALE / FEMALE \*

Your **Nationality**

Your **Ethnicity** (please tick):

#### White

White British ☐ 11  
White Irish ☐ 12  
Other White Background ☐ 19

#### Black or Black British

Black or Black British - Caribbean ☐ 21  
Black or Black British - African ☐ 22  
Other Black background ☐ 29

#### Chinese

Chinese ☐ 34

#### Other Ethnic (please describe)

Other Ethnic background ☐ 80

#### Asian or Asian British

Asian or Asian British - Indian ☐ 31  
Asian or Asian British - Pakistani ☐ 32  
Asian or Asian British - Bangladeshi ☐ 33  
Other Asian background ☐ 39

#### Mixed

Mixed - White and Black Caribbean ☐ 41  
Mixed - White and Black African ☐ 42  
Mixed - White and Asian ☐ 43  
Other Mixed background ☐ 49

**I do not wish to disclose my ethnicity** ☐ 98

Description .....

**Disability** (please tick any which you consider apply to you).

In addition to providing information for HESA, completion of this section will assist the University in understanding the needs and requirements of disabled staff and also allow us to work towards meeting our obligations under the Disability Equality Duty.

- 00 ☐ No known disability  
51 ☐ Specific learning disability (such as dyslexia or dyspraxia)  
52 ☐ General learning disability (such as Down's syndrome)  
53 ☐ Cognitive impairment (such as autistic spectrum disorder or resulting from head injury)  
54 ☐ Long-standing illness or health condition (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy)  
55 ☐ Mental health condition (such as depression or schizophrenia)  
56 ☐ Physical impairment or mobility issues (such as difficulty using arms or using a wheelchair or crutches)  
57 ☐ Deaf or serious hearing impairment  
58 ☐ Blind or serious visual impairment  
96 ☐ Other type of disability  
97 ☐ I do not wish to provide this information