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**Faculty of Science**

**School of Pharmacy and Biomolecular Sciences**

# Certificate of Professional Development in Independent Prescribing for Pharmacists

# **Application form**

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| ***To apply for this course, you must complete the online application form at:*** [***https://uaf.ljmu.ac.uk***](https://uaf.ljmu.ac.uk)*(please ensure that you select the correct programme and entry date)*  **Within 24 hours** of completing the online application, you must upload the following supporting documents:   * A completed version of this form * A completed and signed declaration form from your Designated Medical Practitioner * A completed and signed professional reference, using the template, which must be completed by a registered healthcare professional or with sufficient experience of clinical practice to be able to provide accurate and comprehensive answers to all of the questions on the form * Copies of two of your recent CPD entries (using the GPhC or PSNI format) relating to your proposed scope of prescribing. You should select entries that demonstrate reflection in recognising when something has not worked and the steps taken to rectify this * A copy of the Purchase Order authorising payment of the course from your place of work |

**Applicant’s Name: ………………………………………………………………………………………………..**

1. Please confirm whether you are registered as a pharmacist with the General Pharmaceutical Council (GPhC) or the Pharmaceutical Society of Northern Ireland (PSNI):

**GPhC / PSNI** (Delete as appropriate)

1. What is your GPhC/PSNI registration number?

*(Please note that this will be confirmed by a search of the relevant online register)*

1. In which area of clinical practice do you wish to develop you prescribing skills?

(Please note that this will also be your specialist area of study for 7111CPPHAR)

1. Are your GPhC/PSNI continuing professional development entries are currently up to date?

**Yes / No** (Delete as appropriate)

1. Have you ever applied for, or been a student on, a supplementary or independent prescribing programme in the UK or elsewhere?

**Yes / No** (Delete as appropriate)

If yes, please give details:

1. Are you a member of the Royal Pharmaceutical Society? (if so, please provide your membership number)

**Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / No** (Delete as appropriate)

1. In the table below, please provide details of your current and previous employment in a **UK hospital, community or primary care** setting, that involved patient facing, clinical responsibilities, starting from your first post following your pre-registration training (if applicable). Please make clear where you have gained expertise in the clinical, pharmacological and pharmaceutical knowledge relevant to your intended area of prescribing practice, as identified in question 3.[[1]](#footnote-1)

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| **Job title** | **Employer name** | **Clinical roles/responsibilities** | **Date started** | **Date left** |
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1. Please provide a short statement below which identifies an area of clinical practice in which you intend to develop your prescribing skills and sets out the relevance of your patient-oriented experience to this area of practice. It is also a prerequisite of admission to the course, that the applicant is able to demonstrate how they reflect on their own performance and take responsibility for their own Continuing Professional Development (CPD) including development of networks for support, reflection and learning.

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## Fees

Where were you born? **UK or EU / Outside EU** (Delete as appropriate)

*If ‘’Outside EU”, please state:*

Date of first entry to EU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent entry to EU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date from which you have been granted permanent residence in the EU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were born outside of the UK, you may be asked to complete additional documentation to confirm your fee status. These forms will be forward to you by email, please ensure they are completed and returned as soon as possible.

Please choose one of the following options to indicate who will be paying the programme fees:

☐ I will be paying the **full** programme fee personally

☐ I have a funded place with HEE NW

☐ My employer will be paying the **full** programme fee

Purchase Order Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Both I and my employer are taking **joint responsibility** for paying the programme fee

Please indicate the proportion that…

your employer will pay \_\_\_\_\_\_\_\_% & you are paying \_\_\_\_\_\_\_\_%

## Please submit a copy of the purchase order, just providing the purchase order number is no longer sufficient.

## Declaration

By submitting this application, I declare that the information given in the application is accurate and true to the best of my knowledge. I agree to honour any commitments that I have made to pay course fees. I agree to the university sharing information with my employing organisation if any concerns regarding my Fitness to Practise or the level of support that I require are raised through my studies.

**Please note that a partially completed application will cause delays and may result in you not be offered a place for your chosen start date**

1. If clinical experience is not closely related to your intended area of practice you would be likely to need to gain additional experience, relevant to your selected clinical area. In such circumstances, you may be asked to re-apply for the programme, to start with a later cohort. [↑](#footnote-ref-1)