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| |  | | --- | | **Entry Checklist** | |

**Non-Medical Prescribing Entry Criteria**

**NSA 3900/4900**

**Please complete this Entry Criteria form in pen using BLOCK CAPITALS and upload it when completing your application form.**

**Please also ensure that you have uploaded all the following documentation along with your application form:**

|  |  |  |
| --- | --- | --- |
| Completed application form with all scanned copies of academic qualifications included | **Yes**  🞏 | **No**  🞏 |
| Completed and signed manager statement with educational audit information (see note 1) | **Yes**  🞏 | **No**  🞏 |
| Completed and signed prescribing lead statement | **Yes**  🞏 | **No**  🞏 |
| Scanned copy of proof of DBS which will not expire before the end of the module and is within the last 3 years | **Yes**  🞏 | **No**  🞏 |
| Completed and signed form by designated practice assessor and supervisor (see note 2) | **Yes**  🞏 | **No**  🞏 |
| Supporting statement which highlights your advanced clinical experience, knowledge and skills. | **Yes**  🞏 | **No**  🞏 |

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| **Notes**   1. **The manager should complete the details of the last educational audit, this is usually carried out by the university who provides you with pre-registered nurses. We need to know which university undertook the educational audit, and the date, so we can request this report from them.** 2. **The practice assessor and practice supervisor must be different prescribers. The practice assessor is a V300 independent prescriber nurse or doctor with a minimum of 3 years prescribing experience, who works to the RPS competencies (RPS.2016). The practice supervisor is a V300 independent prescriber nurse or pharmacist, or a doctor with a minimum of 3 years prescribing experience, who works to the RPS competencies (RPS.2016).**   MU LOGO_LDN_RGB.jpg  **Non-Medical Prescribing Entry Criteria**  **NSA 3900/4900**  **Please complete in pen using BLOCK CAPITALS and return with your Application Form** | MU LOGO_LDN_RGB.jpg |

**IMPORTANT:** PLEASE MAKE SURE THAT **YOU AND YOUR LINE MANAGER**

FILL IN APPROPROPRIATE SECTIONS

1. **MANAGER**

**Please tick all the following statements and sign to confirm that:**

|  |  |  |
| --- | --- | --- |
| The applicant is an **employee** of which **at least one year immediately preceding the application for the programme has been in the clinical area** in which the applicant intends to prescribe on successful completion of the programme. | **Yes**  🞏 | **No**  🞏 |
| The applicant has **a good command of written and spoken English** | **Yes**  🞏 | **No**  🞏 |
| The applicant will be given **19 study days to attend the university programme and 12 days for supervised practice** with a Designated Practice Assessor. | **Yes**  🞏 | **No**  🞏 |
| The applicant has been assessed as **competent in clinical history-taking, undertaking clinical assessments and diagnosing** in her/his area of practice | **Yes**  🞏 | **No**  🞏 |
| There is **a clinical need for the applicant to prescribe** within the current role | **Yes**  🞏 | **No**  🞏 |
| The applicant demonstrates **appropriate numeracy skills** | **Yes**  🞏 | **No**  🞏 |
| The applicant **holds a current and satisfactory Disclosure and Barring Service** (within the last three years). See section on main application form as well please | **Yes**  🞏 | **No**  🞏 |
| The **suitability of the applicant has been discussed with the Non-medical Prescribing Lead** for the organisation/primary care trust | **Yes**  🞏 | **No**  🞏 |
| **On successful completion of the prescribing programme the applicant will have access to appropriate Continuous Professional Development activities** | **Yes**  🞏 | **No**  🞏 |
| **Has an educational audit been completed. If yes when was this last done and which university completed**  **the educational audit : Date audit completed ……………………………………University who completed**  **it audit…………………………………………………………………………………………………………** | **Yes**  🞏 | **No**  🞏 |

**Manager’s Signature …………………………………………………………………………………….....................................**

**Name………………………………………………………………………...**

**Address …………………………………………………………………………………………………………………....................**

**Postcode: .............................................**

**Contact details: tel: …………………………………………………… e-mail: ……………………………………....................**

**Date………………………………………**

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| MU LOGO_LDN_RGB.jpg  **Non-Medical Prescribing Entry Criteria**  **NSA 3900/4900**  **Please complete in pen using BLOCK CAPITALS and return with your Application Form** | MU LOGO_LDN_RGB.jpg |

**IMPORTANT:** PLEASE MAKE SURE THAT **YOU AND YOUR LINE MANAGER**

FILL IN APPROPROPRIATE SECTIONS

1. **Non-Medical Prescribing Lead**

**Please tick all the following statements and sign to confirm that:**

|  |  |  |
| --- | --- | --- |
| The applicant is capable of safe and effective practice at a level of proficiency appropriate to be an independent prescriber. | **Yes**  🞏 | **No**  🞏 |
| The applicant has been assessed as **competent in clinical health assessment.** | **Yes**  🞏 | **No**  🞏 |
| The applicant has been assessed as **competent in diagnostics/ care management.** | **Yes**  🞏 | **No**  🞏 |
| The applicant has been assessed as **competent in planning and evaluation of care.** | **Yes**  🞏 | **No**  🞏 |

**Non-Medical Prescribing Lead Signature …………………………………………………………………………………….....................................**

**Name………………………………………………………………………...**

**Address …………………………………………………………………………………………………………………....................**

**Postcode: .............................................**

**Contact details: tel: …………………………………………………… e-mail: ……………………………………....................**

**Date………………………………………**

1. **APPLICANT**

Please identify in which **clinical area(s) you currently work in** ……………………………………………………………………………..........

Please confirm **how long** you have worked in this area …………………………………………………………………………………….............

Which **area(s) of practice are you intending to prescribe in**? ……………………………………………………………………………..........

Are you a 1st level Registered Nurse/Midwife/Health Visitor, Pharmacist or Allied Health Care Professional?

(Delete as appropriate)

If yes, **which part of the Register** are you on ………………………………………………………………………………………..………...........

Please state your **area of Specialist Practice** ………………………………………………………………………………………….……............

Are you undertaking **any other programme of study** at the moment? **Yes** 🞏 **No** 🞏

If yes, please state which programme and indicate when you will be completing:

……………………………………………………………………………………………………………………………………………………...............

Please indicate **when you wish to attend the Prescribing course**:

Start Date………………………………………….……

Have you previously commenced but not completed a prescribing course? **Yes** 🞏 **No** 🞏

If yes please give details?

……………………………………………………………………………………………………………………………………………………...............

**Personal Statement**

(Please complete this section - Use additional pages when necessary)

**You are required to provide a comprehensive supporting statement which should include the following:**

* Evidence of your ability to study at the chosen level. Please give details of recent study including where you studied.
* The need within your service/client group for independent/supplementary non-medical prescribing skills. Give an overview of your client group
* Anexplanation of how you will use this new skill to benefit users of your service.
* An overview of how you have met the entry criteria

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1. **INDEPENDENT / SUPPLEMENTARY NON-MEDICAL PRESCRIBING AGREEMENT WITH SUPERVISION IN PRACTICE SUPPORTER**

**Name of Designated Practice Assessor** …………………………………………………………………………………………………………..….

Qualifications ……………………………………………………………………………………………………………………………………....………

Email …………………………………………………...................................... NMC or GMC number …………………………………………….

Address …………………………………………………………………………………………………………………………………………....……….

Contact Telephone Number …………………………………………………………………………………………………..………………......…….

Are you **a registered medical practitioner** or registered nurse/ midwife who is an independent prescriber who:

1. Has normally had **at least 3 years medical, treatment and prescribing responsibility for a group of patients/clients** in the relevant field of practice, and works to the RPS competencies? **Yes** 🞏 **No** 🞏

**and**

**2.** Is a **specialist registrar, clinical assistant or a consultant or nurse/midwife independent prescriber** within a NHS Trust or other NHS employer holding the equivalent prescribing qualification?

**Yes** 🞏 **No**🞏

**and**

1. Has the support of the employing organisation or GP practice to **act as the designated medical practitioner who will provide supervision, support and opportunities to develop competence** in prescribing practice?

**Yes** 🞏 **No**🞏

**and**

1. Has **some experience or training in teaching and/or supervision** in practice?

**Yes** 🞏 **No** 🞏

**If not an Approved Training Practice/Institution**, then please outline your experience of teaching, supervision and assessment of students.

………………………………………………………………………………………………………………………........................................……..

I confirm that I have agreed to provide for a total of **twelve days** of the programme the training opportunities, supervision, support and assessment for (student) ……………………………….............. to enable her/him to undertake the **Independent / Supplementary Non-Medical Prescribing course**.

**Signature** ………………………………………....………….…… **Date** ………………………....................................………………..………….

**Name of Designated Practice Supervisor** ………………………………………………………………………………………………………..….

Qualifications ……………………………………………………………………………………………………………………………………....………

Are you a V300 or doctor who has had **at least 3 years medical, treatment and prescribing responsibility for a group of patients/clients** in the relevant field of practice, and works to the RPS competencies? **Yes** 🞏 **No** 🞏

Email ………………………………………………….............NMC/ GMC / GPhC number …………………………………………….

Address …………………………………………………………………………………………………………………………....……….

Contact Telephone Number …………………………………………………………………………………………………..………………......…….

**Signature** ………………………………………....………….…… **Date** ………………………....................................………………..………….