

Appendix 4

Application to be included on the Trust Register of NMP once qualified

Name of NMP:.....

Professional Registration Number:.....

Intended type(s) of practice (please circle as appropriate) IP SP*

Date of Qualification:.....

Area of intended clinical practice:.....

For supplementary prescribers only:

State name(s) of responsible clinician(s).....

Job title of responsible clinician(s).....

Signature of responsible clinician(s) & date.....

For LINE MANAGERS OF ALL NMPs:

- I confirm that the job description for this post includes the NMP role as specified in the NMP Policy
- I confirm that I have discussed the need to review ongoing competency to practice as a NMP annually at IPR and agreed how this will be achieved. *State evidence required to demonstrate ongoing competency:*.....
.....
.....
.....

Line Manager's Name..... Job Title.....

Line Manager signature..... Date.....

Signature NMP..... Date.....

*Where the intention is to practice as a Supplementary Prescriber, applicant must submit names(s) and signature(s) of the responsible clinicians they will be working in partnership with (see para. 2.2)

Cont.....

FOR IATMP USE ONLY

Application for (name)..... agreed. Name added to register as IP/SP (circle as appropriate) in the following areas of practice:

Signed:.....Date:.....
Chief Pharmacist

Signed:.....Date:.....
Professional lead (as appropriate to NMP profession)

For NMP Lead:

i) Entered into SFT register of NMPs Date.....

ii) Cost code assigned Date.....

iii) NMP signature entered into pharmacy register Date.....