Appendix 2

Application to train as an NMP

This form should be completed by all staff working within SFT who wish to train as NMPs. This form should only be completed once Trust approval has been obtained from the Expanded Practice Validation group for the development of NMP in a given service – see sections 3.1 and 3.2 above and the Policy for developing an expanded practice protocol.

Name of applicant	
Profession	
Post currently held	
Current grade (for nurses, usually Band 6 or above)	
Area of speciality	
Year of first registration	
Professional Registration No.	
Number of years in practice (minimum requirement see para. 3.3).	
Manager's name	
Manager's designation	
Name of Designated Medical Prescriber (DMP) (must be doctor or dentist)	
Post currently held by DMP	
Area of speciality of DMP	

Cont…..

Applicant statement

1. Please state why you feel that non-medical prescribing will benefit your patients under the following headings:

   Patient safety

   Benefit to patients in terms of quicker and more efficient access to medicines for patients

   Better use of skills of non-medical professionals

2. Please state the clinical areas in which you intend to prescribe as an independent prescriber and/or supplementary prescriber as relevant to your application e.g. management of heart failure.

3. Please indicate your current level of practice in relation to the clinical area in which you intend to prescribe and length of time in this practice e.g. current working alongside an independent prescriber in heart failure clinic for 3 years.

4. Please attach evidence of your ongoing Continuing Professional Development (CPD).

5. Are you receiving any sponsorship for your post Yes/No If so, please give details.

Please state the name of the institution where you intend to train.

Applicant signature:…… Date……..

Cont…….

Line Manager statement

6. Does the candidate have a learning contract with a designated medical practitioner in accordance with the curriculum?

7. Will the service proposed meet a requirement of the local business or service delivery plan? Is there a need for it? Please state how this service will improve the current level of service to your patient population.

8. Is there a plan for continuity and succession?

9. Does the candidate have the specified work experience post registration?

10. Does the candidate have a post-graduate qualification of recent evidence of sufficient therapeutic knowledge and skills in their chosen clinical area to enable them to prescribe safely?

11. Have arrangements been made for release for training?

12. Does the candidate have a current DBS check?

13. Is prescribing identified as a learning need in their PDP?

Line Manager's signature:……
Date……..

Print name:…… Job Title:……

Cont…….

Designated Medical Practitioner's (DMP) statement

14. Please state how long you have worked with the applicant.

15. Please state how you intend to support the trainee prescriber in their practice e.g. clinical training and supervision, regular meetings, assessment of areas of practice, continuing training.

I agree to contribute to and supervise the applicant's learning in practice element of training.

Signed:……..Date:……

Print name:……

Job title: …….

Directorate management team:

This application has been reviewed and is/is not (delete as appropriate) supported by the DMT for this service.

Signed:……. Date:…….

Print name:…….

Job title:…….

FOR IATMP USE ONLY

Approval to train

The following member of staff is approved for training as a Non-Medical Prescriber on behalf of the IATMP/Drug and Therapeutics Committee in the following areas of practice.

Name of Trainee NMP:……

Professional Registration Number:…….

Intended area of practice:……

APPROVED BY:

Relevant professional lead:

Signed:…… Date:……

Name and job title…….

Chief Pharmacist and NMP Lead:

Signed:…… Date:……

Name…….