**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:……………………………………………………………….**

**Smart Card Number (for EPMA training)………………………………………………………..**

**For supplementary prescribers only:**

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

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

Signarure of responsible clinician(s) & date:…………………………………………………….

**For LINE MANAGERS OF ALL NMPs:**

* **I confirm that the job description for this post includes the NMP rolee 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 Manger’s Name: …………………………………………Job Title…………………..

Line Managers’Signature………………………………………Date:………………

**Signature NMP: …………………………………………… Date:.................................**

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

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 in Pharmacy**

1. **Entered into SFT register of NMPs Date……………………………….…………**
2. **Cost code assigned Date…………………………………..…..….**
3. **NMP signature entered into pharmacy register Date……………………………………..…**