



Non-Medical Prescribing

NMC Registration

leedsbeckett.ac.uk

**Application form**

***Please type or write clearly in block capitals. Tick boxes*  *as appropriate***

## Section 1. Declaration of study

Applicant Signature

**Date**

Name (in full)

Do you intend to prescribe for children? YES ☐ NO ☐

Please confirm you have been a registered (NMC) nurse or midwife for a minimum of 12 months. ***\*if NO you will not be able to undertake the course***

YES ☐ \*NO ☐

Have you ever commenced a Non-Medical Prescribing programme at Leeds Beckett University or any other HEI/University and not completed the programme

☐

☐

**YES NO**

Name of previous institution

Name and details of Course/Module Leader

Reason for non- completion

If **YES** please complete the table below and sign If **NO** please sign and go to section 2.

|  |  |  |
| --- | --- | --- |
|  | Year commenced previous study |  |
|  | | |

**Please be aware this information is a standard requirement and if you have answered YES we may need to contact the relevant institution/course tutor**

**Section 2. Manager information – to be completed by your line manager**

*Please request that your line manager completes the information in this section and please ensure that you submit it with your application.*

**Name of applicant**

**IMPORTANT PLEASE READ**

**You MUST agree to the following conditions in support of the above-named persons application for the Non-Medical Prescribing programme.**

1. Confirm that the necessary governance structures are in place (including clinical support, access to

protected learning time and employer support, where appropriate) to enable students to undertake, and ☐

be adequately supported throughout the programme.

1. That the potential student is competent in their own area of practice. ☐
2. That nurse applicants are competent to take a history, make a clinical assessment and make a diagnosis

in their own field of practice OR in undertaking an appropriate programme of study to enable them to do ☐

so.

1. Confirm that the applicant selected to undertake a prescribing programme has the competence, experience and academic ability to study as the level required for that programme.

☐

|  |
| --- |
| ☐ |
| ☐ |
| ☐ |
| ☐ |
| ☐ |

1. That the potential student has numeracy skills consistent with safety in the area in which they intend to prescribe.
2. That there is a need for the applicant to prescribe in their role.
3. Ensure that the applicant has been registered with the NMC for a minimum of one year prior to application for entry onto the programme.
4. Approve the applicant’s choice of Practice Assessor and Practice Supervisor.
5. Agree that the Practice Assessor and Practice Supervisor are suitable to offer support and clinical oversight.

**Title Full name**

**Place of Work/Dept.**

**Does the potential student intend to prescribe for children? YES** ☐ **NO** ☐

**CONFIRMATION OF DBS - PLEASE READ**

**As the line manager you MUST be able to confirm that you have seen their most recent DBS check and confirm the date that this was issued. If this is the annual subscription service, then you MUST confirm you have seen the most recent renewal date.**

Has the applicant had an acceptable DBS check and have you seen it?

YES ☐ NO ☐

If YES please confirm the date their DBS was issued to them.

\*If NO please confirm the DBS has been applied for and is underway

If they subscribe to the annual DBS service please confirm you have witnessed a copy of the most recent renewal date and confirm the date above.

YES ☐ NO ☐

Line Managers Signature

**Date**

**\*Please ensure this is returned to the applicant to submit as part of their full application.**

## Section 3. Practice Assessor – to be completed by your proposed Practice Assessor

Practice Assessors Signature

**Date**

**IMPORTANT PLEASE READ**

**The Practice Assessor MUST be a registered healthcare professional, with a minimum of 2 years post registration experience and a minimum of 2 years active prescribing experience. By completing and signing this form you are agreeing to these standards, if you do not meet these criteria an alternative Practice Assessor MUST be proposed.**

**Name of applicant**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Practice Assessor name**  **Place of work/ Employers Name** | |  | | | |
|  | | | |
| **Main place of work address** | | | **Daily contact address** | | |
| **Postcode Telephone No.**  **Job Title** |  | | **Postcode** | |  |
|  | | **Email**  **Length of in role** |  | |
|  | | **time** |  |

1. Have you had 2 years recent prescribing experience in a field of practice relevant to that in which the potential student will be prescribing?
2. Do you have the support of the employing organisation or GP practice to act as a Practice Assessor who will provide supervision, support and opportunity to develop/acquire competence in prescribing practice?

YES ☐ NO ☐

YES ☐ NO ☐

**Professional Qualification Date achieved**

**\*Please ensure this is returned to the applicant to submit as part of their full application.**

## Section 4. Practice Supervisor – to be completed by your proposed Practice Supervisor

Practice Supervisors Signature

**Date**

**IMPORTANT PLEASE READ**

**The Practice Supervisor MUST ideally be a practitioner with clinical oversight, to support the student and the Practice Assessor.**

**Name of applicant**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Practice Supervisor name**  **Place of work/ Employers Name** | |  | | | |
|  | | | |
| **Main place of work address** | | | **Daily contact address** | | |
| **Postcode Telephone No.**  **Job Title** |  | | **Postcode** | |  |
|  | | **Email**  **Length of in role** |  | |
|  | | **time** |  |

1. Have you had recent prescribing experience in a field of practice relevant to that in which the potential student will be prescribing?
2. Do you have the support of the employing organisation or GP practice to act as a Practice Supervisor who will provide supervision, support and opportunity to develop/acquire competence in prescribing practice?

YES ☐ NO ☐

YES ☐ NO ☐

**Professional Qualification Date achieved**

**\*Please ensure this is returned to the applicant to submit as part of their full application.**

## Section 5. Non-Medical Prescribing Lead – to be completed by your proposed NMP Lead.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Main place of work address** | | **Daily contact address** | | |
| **Postcode Telephone No.**  **Job Title** |  | **Postcode** | |  |
|  | **Email**  **Length of in role** |  | |
|  | **time** |  |

**\*Please ensure this is returned to the applicant to submit as part of their full application.**

NMP Lead Signature

**Date**

**IMPORTANT PLEASE READ**

**As the identified Non-Medical Prescribing Lead, you MUST complete the information below. Name of applicant**

**Name**

**What to do next**

Please send your completed application form to [directadmissions@leedsbeckett.ac.uk](mailto:directadmissions@leedsbeckett.ac.uk%20) note that currently we cannot accept postal applications.