

**Faculty of Health and Wellbeing**

**Application Form for Community Practitioner Nurse Prescribing (V150) 2011/2012**

**Please indicate the health authority you are applying from:**

- Yorkshire and Humber Strategic Health Authority       East Midlands Healthcare Workforce Deanery

**Please indicate which Semester you are applying for:**     Semester 1       Semester 2

**1 TRUST OR ORGANISATION - PLEASE COMPLETE**

**I confirm that:**

- the Trust or Organisation named below has authorised the person named on this application form to receive funding for this module.
- the applicant has been registered with the NMC for a minimum of two years
- the applicant is deemed competent to undertake the programme
- the applicant intends to practice in an area of clinical need for which prescribing from the community practitioner formulary will improve patient / client care and service delivery.
- the applicant's CRB status has been checked within the last 3 yrs

Name of Trust or Organisation: .....

Signature of Organisation Non Medical Prescribing Lead: .....

PRINT NAME: ..... Email: ..... Date: .....

Signature of Line Manager: .....

PRINT NAME: ..... Email: ..... Date: .....

**2 ALL APPLICANTS - PLEASE COMPLETE**

TITLE (e.g. MR, MS, DR)	DOB:	SEX (M/F):
FAMILY NAME:	PREVIOUS SURNAME:	
FIRST NAMES:		
HOME ADDRESS:	WORK ADDRESS:	
POSTCODE:	POSTCODE:	
HOME TEL NO:	WORK TEL NO:	
MOBILE TEL NO:	WORK MOBILE TEL NO:	
EMAIL ADDRESS:	WORK EMAIL ADDRESS:	
NMC Registration Number:	Date of Registration:	

<b>Have you undertaken a prescribing course before?</b>
(if yes, please give details of previous application and University)

**3 DESIGNATED PRACTICE TEACHER / SIGN-OFF MENTOR- PLEASE COMPLETE**

NAME:		
ORGANISATION (PLACEMENT) NAME AND ADDRESS:		
TELEPHONE:	EMAIL ADDRESS:	
SIGNATURE:	DATE:	
<b>PROFESSIONAL QUALIFICATIONS</b>	<b>Date Obtained</b>	
<b>TEACHING / MENTOR QUALIFICATION (S)</b>	<b>Date Obtained</b>	
<b>Recent professional development e.g. conferences / study days / learning units to support prescribing role</b>		
Have you had 3 years recent prescribing experience in a relevant field of practice?	<b>Yes</b>	<b>No</b>
Do you have the support of the employing organisation to act as a Mentor or Practice Teacher who will provide supervision, support and opportunity to develop / acquire competence in prescribing practice?	<b>Yes</b>	<b>No</b>
Are you on the Local Register as a Practice Teacher or Mentor?	<b>Yes</b>	<b>No</b>
Date of most recent Placement Audit		
Date of most recent Mentor / Practice Teacher update		

Return this form **at least 5 weeks** prior to course commencement to: The Business Development Team, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, S10 2BP. Please be aware that funding is allocated on a first come first served basis therefore early application is recommended

## Application Form for Community Practitioner Nurse Prescribing (V150)

Please complete Section A (if you are an existing student) and Section B for all applicants

### Section A - to be completed if you are currently undertaking other study

I am currently enrolled student at _____ University
My Student Number is: _____
The course on which I am currently enrolled is: _____

### Section B - to be completed by all applicants

(this information will be used to assess your suitability for the named course or module/s for which you are seeking funding)

#### 4 ACADEMIC AND PROFESSIONAL QUALIFICATIONS

Examining Body (Organisation responsible for your qualification)	Subject (e.g. Nursing, Physiotherapy, Pharmacy etc)	Type (e.g. Advanced Dip, BA, Credit only - state credit gained)	Professional Qualification (e.g. RGN, RMN etc. where relevant)	Year (of award)

#### 5 FURTHER CONTINUING PROFESSIONAL DEVELOPMENT COURSES UNDERTAKEN

Examining Body (Organisation responsible for your qualification) / award	Subject (e.g. Nursing, Physiotherapy, Pharmacy etc)	Level of Study	Credit Awarded	Year (of award)

Return this form **at least 5 weeks** prior to course commencement to: The Business Development Team, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, S10 2BP. Please be aware that funding is allocated on a first come first served basis therefore early application is recommended

## 6 EMPLOYMENT

### EMPLOYMENT

Please list your present post first, followed by other posts you have held in the last 10 years

Names and addresses of employers	Post held	Dates

## 7 FURTHER INFORMATION

**Please give further information in support of your application. Include reasons why you wish to undertake prescribing from the Community Practitioner Formulary, giving information regarding how prescribing will facilitate your practice development and enhance patient care.**

Please continue on a separate sheet if necessary

### Anticipated prescribing opportunities

**Please indicate the range of medications and products that you anticipate being able to prescribe in your practice, and the approximate number of patients per annum**

## 8 Disabilities and support needs

Type of disability	
<input type="checkbox"/> Dyslexia	<input type="checkbox"/> Blind/partially sighted
<input type="checkbox"/> Deaf/hearing impairment	<input type="checkbox"/> Wheelchair user/mobility difficulty
<input type="checkbox"/> Autistic spectrum disorder/Asperger syndrome	<input type="checkbox"/> Mental health difficulty
<input type="checkbox"/> Multiple difficulties	<input type="checkbox"/> Personal Care Support
<input type="checkbox"/> 'Hidden disabilities' (diabetes, epilepsy, asthma etc)	<input type="text" value="please specify"/>
Other	<input type="text" value="please specify"/>
Nature of support required	

## 9 Equal opportunities monitoring

<b>Ethnic origin</b>	
<input type="checkbox"/> White	<input type="checkbox"/> Pakistani
<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Bangladeshi
<input type="checkbox"/> Black African	<input type="checkbox"/> Chinese
<input type="checkbox"/> Black Other	<input type="checkbox"/> Asian Other
<input type="checkbox"/> Indian	<input type="checkbox"/> Other
<input type="text" value="please specify"/>	

<b>Religion</b>
-----------------

<b>Number of dependents</b>
-----------------------------

Return this form **at least 5 weeks** prior to course commencement to: The Business Development Team, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, S10 2BP. Please be aware that funding is allocated on a first come first served basis therefore early application is recommended

**10. I confirm that, to the best of my knowledge, the information given on this form is correct and complete. I agree to the disclosure of my data to my named sponsor.**

**Applicant's Signature:** ..... **Date:** .....

*For Sheffield Hallam University use only*

**Approved by Course Leader** .....

**Date** .....

### **Data Protection Statement**

*Information supplied will be used in accordance with the Data Protection Act 1998 and other applicable legislation. From time to time the University may use this information to keep you informed of services and activities, to seek your feedback on these and to inform you of events held in conjunction with a third party. The University does not share this information with third parties, except agencies working on our behalf and ensures that such agencies handle information in accordance with the Data Protection Act.*

*Please tick if you **do not** wish to receive information about University services [ ], University events [ ], alumni services [ ]*

*Please tick if you **do not** wish to receive information by Email [ ] or Text [ ]*

*If at any time you change your mind and would like the University to stop sending such information, please contact **Faculty of Health and Wellbeing, Sheffield Hallam University, Collegiate Campus, S10 2BP***

**Please return this form to your NMP lead, who will forward to Sheffield Hallam University**