

**Applicant Services**

Northumbria University

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**Prescribing Authorisations form**

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

|  |  |
| --- | --- |
| **Name of Applicant(s):** |  |
| **Date of Birth:** |  |
| **Module (select from list):** |  |
| **Name of Organisation:** |  |
| **Role:** |  |
| **Applicant e-mail:** |  |
| **Applicant Signature:** |  |

By signing this form, you are confirming that the information enclosed is accurate and correct to the best of your current knowledge. You are also confirming you;

* Have the competence, experience and academic ability to study at the requested level.
* Are capable of safe and effective practice in their intended area of prescribing practice in the following areas:
* Clinical/health assessment
* Diagnostics/care management
* Planning and evaluation of care

**SECTION 2 – TO BE COMPLETED BY AUTHORISER/APPROPRIATE OTHER**

|  |  |
| --- | --- |
| **Name of Authoriser:** |  |
| **Role:** |  |
| **Name of Organisation:** |  |
| **Authorising Staff Member e-mail:** |  |
| **Authorising Staff Member Signature:** |  |

By signing this form, you are agreeing to this applicant attending their chosen module and that they are eligible for this course of study. You are also confirming that the following are in place:

* Valid DBS
* Access to protected learning time
* Clinical support

Please note this needs to be an actual signature and not a typed signature.

**SECTION 3 – TO BE COMPLETED BY PRESCRIBING LEAD/AUTHORISER**

Please note – if you are a self-employed/Non NHS funded applicant you do **not** need to complete this section if the information is the same as that in section 2.

|  |  |
| --- | --- |
| **Name of PPF/Prescribing Lead:** |  |
| **Name of Organisation:** |  |
| **Authorising Staff Member e-mail:** |  |
| **Authorising Staff Member Signature:** |  |

By signing this form, you are agreeing to this applicant attending their chosen module and that they are eligible for this course of study. You are also confirming the applicant is capable of safe and effective practice in their intended area of prescribing practice in the following areas:

* Clinical/health assessment
* Diagnostics/care management
* Planning and evaluation of care

Please note this needs to be an actual signature and not a typed signature.

**SECTION 4 – PRACTICE SUPERVISOR AND PRACTICE ASSESSOR DETAILS**

Please note – for HCPC Registrants your Practice Assessor and Practice Supervisor can be the same person.

For NMC/Self-Employed/Aesthetic applicants your Practice Assessor and Practice Supervisor should be **different** people.

If you require further advice on the roles of the Practice Supervisor and Practice Assessor, further information can be found in the **supplementary information** available on the Programme webpage.

|  |  |
| --- | --- |
| **Name of Practice Supervisor:** |  |
| **Role:** |  |
| **Practice Supervisor email address:** |  |
| **Practice Supervisor Professional Registration PIN:** |  |

|  |  |
| --- | --- |
| **Name of Practice Assessor:** |  |
| **Role:** |  |
| **Practice Supervisor email address:** |  |
| **Practice Supervisor Professional Registration PIN:** |  |

All sections of this form **MUST** be signed and completed and returned to Applicant Services before an applicant’s place on a CWD module can be confirmed.

If you have already submitted your application, please log into your Applicant Portal and upload this to your application, or return it to nsbackoffice@northumbria.ac.uk, confirming your name and student number in the subject heading.