

**Applicant Services**

Northumbria University

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**Prescribing Authorisations form**

**Please do not type/cut & paste signatures. All forms must be hand signed.**

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

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

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| **Name of Applicant(s):** |  |
| **Date of Birth:** |  |
| **Module (select from list):** |  |
| **Name of Organisation:** |  |
| **Role:** |  |
| **I declare I have/have not studies prescribing at another University** | If yes, please provide details of previous study |
| **Applicant e-mail:** |  |
| **I declare there is no relationship between myself, PA/PS or authoriser named below (other than professional working relationship)** |  |
| **Applicant Signature:** |  |
| **Date** |  |

**SECTION 2 – TO BE COMPLETED BY PRESCRIBING LEAD (Trust prescribing lead/non-medical prescribing lead within the organisation)**

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.

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

**SECTION 3 – TO BE COMPLETED BY AUTHORISER/APPROPRIATE OTHER (Manager etc)**

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 Enhanced DBS certificate (issued within 3 years of applying to this course)
* Access to protected learning time
* Clinical support

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

**Signature of authoriser (if self-employed/non NHS applicant) agreeing that they are taking responsibility for the confirmation of section 2 and 3 criteria.** Please note you are confirming in section 2 and 3 criteria regarding clinical skills, DBS, learning time and support.

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| **Name of Authoriser:** |  |
| **Authorising Staff Member Signature:** |  |
| **Date** |  |

**SECTION 4 – PRACTICE SUPERVISOR AND PRACTICE ASSESSOR DETAILS (Designated Prescribing Practitioner/s).**

Please note – for HCPC Registrants, you require a Practice Assessor only.

For all NMC applicants, your Practice Assessor and Practice Supervisor should be **different** people.

Practice Assessors must have attended the Northumbria University specific non-medical prescribing assessment briefing previously, or indicate that they need to attend one.

If you require further advice on the roles of the Practice Supervisor and Practice Assessor, further information can be found at the end of this from.

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| --- | --- |
| **Name of Practice Supervisor:** |  |
| **Role:** |  |
| **Practice Supervisor email address:** |  |
| **Practice Supervisor Professional Registration PIN:** |  |
| **I confirm I have read and meet the standards of Practice Supervisor (Yes/No)** |  |
| **Signature** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **Name of Practice Assessor:** |  |
| **Role:** |  |
| **Practice Assessor email address:** |  |
| **Practice Assessor Professional Registration PIN:** |  |
| **I confirm I have read and meet the standards of Practice Supervisor (Yes/No)** |  |
| **Need to attend PA briefing (Yes/No)** |  |
| **Signature** |  |
| **Date** |  |

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 considered.

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](mailto:nsbackoffice@northumbria.ac.uk), confirming your name and student number in the subject heading.

## **Designated Prescribing Practitioner/Practice Assessor/Supervisor information (Royal Pharmaceutical Society, Health and Care Professionals, and Nursing and Midwifery Council standards)**

* The Practice Supervisor
* Must be registered nurse, midwife, allied health professional or doctor who
* Is an active, registered prescriber, usually with three years’ experience.
* Works in the same clinical area as the prescribing student
* Is a role model for safe and effective practice
* Has up to date knowledge of skills of prescribing in the clinical area
* Is able to commit time to supervise and support the student
* If a Designated Medical Practitioner, then they must meet the Department of Health criteria below

**The Practice Assessor**

Nurses and other non-medical prescribers undertaking the role of practice assessors must meet the Department of Nursing, Midwifery and Health role eligibility criteria below. This criteria has been developed in partnership with local NHS Trusts, and follows the RPS guidance for DPPS.

**The practice assessor must:**

* Be a registrant on health professions register.
* Be a V300 or medical prescriber, usually with three years prescribing experience.
* Have some experience or training in teaching and / or supervising and assessing in practice
* Have agreement from the line manager for time to support the nurse prescribing student
* Be willing to undertake Preparation for Assessing Prescribers
* If a Designated Medical Practitioner, then they must meet the Department of Health criteria below

**Department of Health eligibility criteria to act as the Designated Medical Practitioner for the assessment of non-medical prescribers by medical prescribers.**

* has normally at least 3 years recent clinical experience for a group of patients/clients in the relevant field of practice.
* is within a GP practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the joint committee for Post-graduate Training in General Practice (JCPTGP)

**OR**

* is a specialist registrar, clinical assistant or a consultant within an NHS Trust or other NHS employer.
* Has the support of the employing organisation or GP practice to act as the designated medical practitioner who will provide supervision, support and opportunities to develop competence in prescribing practice.
* Has some experience or training in teaching and / or supervising in practice