



NI Centre for
Pharmacy Learning
& Development

Non-medical prescribing

CONFIRMATION OF ELIGIBILITY

Pharmacist registration number:	
---------------------------------	--

Full name of pharmacist:	
--------------------------	--

Please provide evidence of at least 2 years appropriate patient orientated practice in hospital/community/primary care following your pre-registration year. (In addition to describing your patient orientated practice, you can attach a CV and appropriate references in support of your application)

For which clinical area(s) will you be prescribing? (e.g. renal, diabetes, anti-coagulation)

What is the name of your designated medical practitioner (DMP)?

I provide the following summary to demonstrate how I reflect on my own performance and take responsibility for my own CPD and how I have developed my own support networks for the CPD of prescribing practice, including prescribers from other professions

--

I confirm that I have up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to my intended area of prescribing practice.

Pharmacist signature:	
------------------------------	--

Date:	
--------------	--

Day time tel no:		email:	
-------------------------	--	---------------	--



Non-medical prescribing

TPM/SPONSORING ORGANISATION AGREEMENT

Pharmacist registration number:	
---------------------------------	--

Full name of pharmacist:	
--------------------------	--

I		<i>(inset full name and job title)</i>
---	--	--

support the training, as an Independent Prescriber, of the above named pharmacist based at the following establishment:

--

(Insert full name and address of training establishment)

and declare that there is an identified service need for the extension of this role and that they will have the appropriate supervised practice in the clinical area(s) in which they will be prescribing.

--

(Insert title of clinical area(s))

Subject to satisfactory completion of the course, I declare that this pharmacist will practise as a Supplementary and/or Independent Prescriber in

--

(Insert title of clinical area(s))

based at

--

(Insert full name and address of training establishment)

Trust Pharmacy Manager / Sponsor's signature:		Date:	
---	--	-------	--



Non-medical prescribing

DESIGNATED MEDICAL PRACTITIONER AGREEMENT

Pharmacist registration number:	
---------------------------------	--

Full name of pharmacist:	
--------------------------	--

Full home address of pharmacist	

I		<i>(insert full name of medical practitioner)</i>
---	--	---

agree to be the prescribing mentor of the above named pharmacist, based at the following establishment

(Insert full name and address of training establishment)

I declare that I have experience in a relevant field of practice and training and experience in the supervision, support and assessment of trainees. I declare that I am familiar with the learning outcomes for the programme and my role in delivering these.
--

I agree to: <ul style="list-style-type: none">• Provide the pharmacist with opportunities to develop competencies in prescribing• Supervise, support and assess the pharmacist during their clinical placement.• Assess the pharmacist's clinical competence in the area they will be prescribing
--

Medical practitioner signature:	
---------------------------------	--

Date:	
-------	--

Pharmacist signature:	
-----------------------	--

Date:	
-------	--