

Medicines Management Accredited Programme

MMAP

CANDIDATE INFORMATION AND DECLARATION

Full name of pharmacy technician:

PSNI no:

Email address:

Work establishment:

Date of qualification:

I wish to enrol onto the MMAP module(s) indicated below and agree to undertake the relevant practice activities to develop and demonstrate my competence.

Foundation Module – Working in a Clinical Environment

Module 1 – The supply of medication to individual patient

Module 2 – The assessment of patients' own drugs (PODs)

Module 3 – Medicines reconciliation 1 (Drug History)

Module 4 – Patient Medication Counselling

Candidate signature:

Date:

DECLARATION BY EDUCATIONAL SUPERVISOR

Full name of ES:

PSNI no:

Email address:

I confirm that:

- I am a registered occupationally competent pharmacist with 2 years post registration experience **or** a medicines management accredited pharmacy technician with a minimum of 2 years' post-accreditation experience in the module(s) I will be facilitating.
- I have completed the NICPLD 'Effective mentoring' online course
- I have attended the MMAP educational supervisor training
- I have experience in supporting the professional development of pharmacy colleagues

I agree to support this pharmacy technician with the MMAP Module(s) they are undertaking

ES signature:

Date:

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DECLARATION BY MANAGER

Full name of Clinical Pharmacy Manager:

I support this pharmacy technician's enrolment onto the Medicines Management Programme

I confirm that:

- the candidate meets the criteria outlined for entry onto the programme
- the necessary training and support of their professional development will be provided at the above-named work establishment
- this will be provided by an appropriately trained Educational Supervisor who is competent to take on this role

Clinical Pharmacy Manager signature:

Date: