**Non-Medical Prescribers - Approval to Practice form/Annual Declaration**

This form must be returned before the non-medical prescriber can be registered with the NHSBSA and prescribe in the practice.

It must be updated annually and before any changes are made to prescribing practice.

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| **DECLARATION:** NEW APPLICATION  UPDATED  ANNUAL DECLARATION  (please cross box as appropriate) | | | | | |
| **Prescriber’s name:** |  | | **Title:** | | Mr / Mrs / Miss / Ms |
| **Professional registration no.:** (NMC/GPhC no. or equivalent) |  | | **Community Practitioner Nurse Prescriber Formulary**  **Nurse Independent Prescriber Formulary**  (please cross the box as appropriate) | | |
| **Profession:**: e.g. Nurse / Pharmacist |  | |
| **Base/Practice:** |  | | **Practice code:** | |  |
| **Date that the prescriber commenced/will commence prescribing at the practice:** |  | | **Tel. No:** | |  |
| **Contact email address:** |  | | **Mentor/Lead Clinician**  (medical practitioner) | |  |
| Are you prescribing - Manually  Electronically  (Please cross relevant boxes) | | | | | |
| **Do you work as a prescriber in another Provider / Practice?** | YES / NO | **Name of Provider/CCG/Practice:** | |  | |
| **Will you prescribe Schedule 2–5 Controlled Drugs?**  **YES / NO** | (Please cross  relevant boxes)  Schedule 2  e.g. diamorphine, fentanyl  Schedule 3  e.g. temazepam, pregabalin, gabapentin  Schedule 4  e.g. zopiclone, diazepam, testosterone  Schedule 5  e.g. Codeine based preparations, pholcodine | | | | |
| **Will you prescribe for children under 12 years old?** YES / NO | | | | | |

**Table 1: Scope of Prescribing Practice**

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| --- | --- | --- | --- |
| *The following areas of practice have been identified as appropriate for nurse prescribing, in line with the British National Formulary categories.* ***Please cross each box (*** ***) as appropriate.*** | | | |
| **Chapter 1: Gastro – intestinal system** |  | **Chapter 2: Cardiovascular system** |  |
| **Chapter 3: Respiratory system** |  | **Chapter 4: Nervous system** |  |
| **Chapter 5: Infections** |  | **Chapter 6: Endocrine system** |  |
| **Chapter 7: Genito-urinary system** |  | **Chapter 8: Malignant disease** |  |
| **Chapter 9: Blood and Nutrition** |  | **Chapter 10: Musculoskeletal system** |  |
| **Chapter 11: Eye** |  | **Chapter 12: Ear, Nose & Oropharynx** |  |
| **Chapter 13: Skin** |  | **Chapter 14: Vaccines** |  |
| **Chapter 15: Anaesthesia** |  | **Other:**   * **Wound management products** * **Elasticated garments** |  |

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| In line with the Policy for Non-Medical Prescribing, Administration and Practice, I have discussed and agreed my areas of practice and competence with my GP mentor and they confirm that I am competent to take a patient history, undertake a clinical assessment and diagnose within the area and field of practice identified.  The GP mentor is responsible for providing support and mentorship and for monitoring competencies, prescribing and the prescriber’s CPD portfolio at agreed intervals (minimum once per year)  **Signing this form provides an assurance regarding its review** | | | |
|  | **NAME** | **SIGNATURE** | **DATE** |
| **Prescriber** | …..………………………... | …………………………………………….. | …………………… |
| **Lead Clinician** | ……….…………………… | …………………………………………….. | …………………… |
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| **The prescriber’s scope of practice must be reviewed and this form amended and approved before any additions in prescribing practice. This form will need to be submitted annually.** | | | |
| **Please email completed forms to:** mlcsu.nmpregister@nhs.net  **Alternatively please post completed and signed forms to**: Medicines Management team, Midlands and Lancashire Commissioning Support Unit, Jubilee House, Lancashire Business Park, Centurion Way, Leyland, PR26 6TR. | | | |
| **PLEASE ENSURE THAT YOU INFORM US PROMPTLY IF ANY OF THE NMP’S DETAILS CHANGE OR THE NMP LEAVES THE EMPLOYMENT OF THIS PRACTICE SO THAT THEIR DETAILS CAN BE UPDATED WITH THE NHSBSA** | | | |

**SUPPLEMENTARY FORM FOR COMPLETION BY NMPs WORKING ACROSS MULTIPLE PRACTICES**

**NMP Details**

|  |  |
| --- | --- |
| Full Name |  |
| Title (e.g. Mr / Mrs / Miss / Ms) |  |
| Contact email address |  |
| Professional Registration No. |  |

**To be completed by the Lead Clinician of hosting practice / employing organisation**

I can confirm as Lead Clinician of the applicant’s hosting practice that I take responsibility for the oversight of the applicant’s prescribing competencies working across all the practices they are registered with.

Lead Clinician’s Signature: ........................................................ Name (**PLEASE PRINT**): …...……………………………….………………………

Date: …………………………………………………………………… Lead Clinician contact details: …………………………………………..………….

**To be completed by the Lead Clinician of each additional practice where the NMP will prescribe**

**By signing this form, practices are authorising the MLCSU to register the NMP with the NHS Business Services Authority as a prescriber for the practices below. Oversight of prescribing will rest with the Lead Clinician of the hosting employer/employing organisation as above.**

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| --- | --- | --- | --- | --- | --- |
| Practice Name | Practice Address | Practice Code | NMP start date at practice (dd/mm/yy) | Lead clinician of practice (PRINT NAME) | Lead clinician of practice (Signature) |
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