**Joint Schools of Pharmacy Programme**

**PRE-ADMISSION FORM**

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Postgraduate Certificate in Clinical Pharmacy in Prescribing Postgraduate Certificate in Pharmacist Prescribing

**University you intend to apply for admission to:** University of Auckland University of Otago (tick chosen option)

 **Personal Details**

 Name:

 Address:

 Email:

 Phone:

 **Employment Details**

 Name and address of

 Current employer(s):

Position/Job Title:

PCNZ APC No:

 **DECLARATION MUST BE COMPLETED**

 I, the abovenamed, declare the following is true and correct:

 1. I hold a current Annual Practising Certificate (APC) and registration in the Pharmacist Scope of Practice in New Zealand.

 2. I have at least two years’ recent experience within a collaborative health team environment and I have discussed and identified my possible role(s) as a prescriber with this collaborative health team.

 3. PCNZ Competence Standards 1, 2, 4 and 5 of the Pharmacist Scope of Practice are applicable and part of my current practice.

 4. I have identified potential Designated Medical Practitioners (DMPs) to provide supervision, support and shadowing opportunities during the Practicum.

 5. I have up-to-date clinical, pharmacological and pharmaceutical knowledge in the clinical area(s) in which I intend to prescribe.

 6. I reflect on my performance as a pharmacist and take responsibility for my own CPD.

 Signed:

 Date:

 **Supporting documentation required to be submitted for pre-admission**

 • A copy of your academic transcript.

 • A copy of CV of employment history.

***FOR OFFICE USE ONLY:*** Please provide this additional information.

 **Please provide the name of your Manager who has agreed to support your application, including the requirement to complete 150 hours of supervised practice during the Prescribing Programme (approx. April to October).**

 Name:

 Position:

Organisation:

 Signature of manager:Date:

 **Describe below the area of clinical practice in which you will develop your prescribing skills over the course:**

 Which group(s) of patients?

What disease states?

What speciality?

What practice setting?

 e.g. Community,

 GP Practice,

 Hospital inpatient,

 Outpatient clinic

Other comments

 Please provide a statement in support of your application. Include a description of your current patient orientated practice, how you intend to develop a prescribing role and how this will benefit patient care (750 words or less).

**This section is to be completed by the Designated Medical Practitioner who has agreed to provide supervision during the Prescribing programme (approx April – October).**

 Name:

 Position:

 Organisation:

 Work address:

Telephone Number:Email address:

The Designated Medical Practitioner (DMP) must meet all the criteria below. Please tick the appropriate boxes:

Are you a Consultant, General Practitioner or Senior Registrar?

Do you have recent clinical experience for a group of patients in the relevant field of practice to the applicant?

Do you have some experience or training in teaching and/or supervision?

Have you read the information provided by the University on the role and responsibilities of the DMP?

Signature of Designated Medical Practitioner: Date:

 **This section is to be completed by the Clinical Leader of the applicant’s Collaborative Healthcare Team**

I verify that the applicant has discussed and identified their possible role(s) as a prescriber within their Collaborative Healthcare Team

Name:

Position:

Organisation:

Signature of Clinical Leader: Date: