**Supported by NHS England and Health Education England**

**through the Pharmacy Integration Fund**

**Post-registration Training for Community Pharmacists**

**Supporting evidence for funding for community pharmacist**

**post-registration training through the Pharmacy Integration Fund.**

***Please complete this form and upload with your online application***

***Please indicate your main practice base area:***

[ ]  **South West and South Central (B&NES, Berkshire, Bristol/North Somerset/South Gloucestershire, Buckinghamshire, Cornwall, Devon, Dorset, Gloucestershire, Hampshire/IOW, Oxfordshire, Somerset, Wiltshire)**

[ ]  **London and South East (Kent, Surrey, Sussex)**

[ ]  **Midlands and North (West & East Midlands, Yorkshire & The Humber, North West, North East)**

|  |  |
| --- | --- |
| **Full name of applicant** |  |
| **GPhC registration number** |  |
| **Employment** | **Please indicate if you are:**[ ] Employed by a community pharmacy[ ] A locum pharmacist in community pharmacy**Please indicate the type of community pharmacy role you have:**[ ] Community [ ] Health & Justice sector [ ] Hospital out-patient department[ ] Within a GP practice/primary care health centre [ ] Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Contracted hours per week** | Applicants are required to be in current employment in community pharmacy or Health and Justice pharmacy services (provided by NHS, private organisations or acute trusts) for a minimum of 0.4 WTE (15 hours per week).\_\_\_\_\_\_ hours per week  |
| **Practice Base**  | Employer name & Address:Postcode: \_\_\_\_\_\_  |
| **Services that you offer** | Please state the services that you are personally accredited to provide e.g. Medicines use review (MUR), New medicines service (NMS), or working as part of a Level 1 (or above) Healthy Living Pharmacy: |
| **Confirmations to meet HEE funding criteria (please tick)** | [ ]  I commit to share information and participate in the development of case studies to demonstrate the impact of my role as part of the transformation of pharmacy services (and consent for this information to be shared with third parties, e.g. Health Education England, NHS England and anyone appointed by NHS England to undertake evaluation).[ ]  I commit to be part of a future evaluation of the impact of my new skills on service delivery.[ ]  I confirm that I am **not** enrolled on any of the following NHS England Service Pathways: * Integrating Pharmacy into Urgent Care
* Pharmacy Integration in Care homes
* Clinical Pharmacists in General Practice

[ ]  I understand that if any of the above information changes I will notify the University of Bath immediately. [ ]  I understand that any false declaration will result in my funding being withdrawn and any accrued fees owed being charged to me personally. |
| **Fitness to practise** | [ ]  I confirm that I am currently fit to practise in accordance with the GPhC requirements. |
| **Commitment to study** | [ ]  I confirm that I will commit to attending the necessary workshops and complete relevant work-based activities. I will secure employer support if required to complete these activities.  |
| **Course Options** | **Please indicate which route you are likely to study:**  [ ]  I am planning on studying the **2 compulsory units** (Professional Skills for Medicines Optimisation & Evidence Based Pharmacy Practice), followed by **3 optional units** of my choice. Further information regarding the unit options can be found here:<http://www.bath.ac.uk/study/pg/programmes/funded-clin-comm-phar/index.html>[ ]  I am planning on taking stand-alone CPD units (please give details below): |
| **Credit transfer**  | **Please indicate whether you would like to be considered for credit transfer (for PG Cert & Dip applications only) - the admin team will contact you for further information**[ ]  I have completed Independent Prescribing [ ]  I have another credit-bearing qualification. Please give further details below: |
| **Applicant**  | **Signature:****Date:** |