

## **Advanced Programmes in Pharmaceutical Practice and Therapeutics (AP3T)**

## Confirmation of Employer Support

This form is designed to ensure that the applicant has sufficient **educational** support from their employer to allow them to complete their chosen course or unit(s) of study. There is a separate form for the employer to declare any financial support of the applicant.

If necessary, **we will contact the person named on this form** in Section 3 to confirm that the information provided is accurate and the employer support declared has been agreed to.

## **Section 1: Applicant Details**

|  |  |
| --- | --- |
| Applicant name (as it appears on professional registration) |  |
| Course or Unit applied for  *For example, Independent Prescribing unit or Secondary Care Diploma* |  |
| Applicant email address |  |
| Applicant telephone number |  |

## **Section 2: Employment details**

|  |  |
| --- | --- |
| Name of employing organisation |  |
| Address |  |
| Telephone number |  |

## **Section 3: Employer’s Education & Training Contact**

|  |  |
| --- | --- |
| Contact Name |  |
| Role |  |
| Telephone number |  |
| Workplace email |  |

## **Section 4: Suitability of workplace setting to support study**

*To be completed by a representative of the employing organisation*

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| --- | --- |
| **Please respond to all the following statements by adding Yes (or No) in the column to the right** | |
| The applicant is employed in a role in which they deliver patient care. |  |
| The applicant is employed in a role in which they have access to a range of clinical environments (including access to patient records) appropriate to their proposed course or unit(s) of study. |  |
| The applicant will be allocated a workplace mentor with responsibility for supporting their study and providing feedback on assignments. Please note this role is ***optional*** for the **Primary Care** programme.  *For the Independent Prescribing unit, this person is often the Designated Prescribing Practitioner, although a student may have another mentor in addition.* |  |

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| Please add any other relevant comments about this study’s access to opportunities for learning in their workplace |
|  |

## **Section 5: For applicants to the Independent Prescribing and/or Advanced Clinical Assessment Units only**

*To be completed by a representative of the employing organisation*

If the applicant is **not** applying to study either the Independent Prescribing and/or Advanced Clinical Assessment units, please go straight to Section 6.

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| --- | --- |
| Is the student to complete clinical hours required in an organisation in which they are employed?  *The requirements are 90 hours for Independent Prescribing and 25 hours for Advanced Clinical Assessment* |  |

If the applicant will be seeing patients within an organisation in which they are **not employed,** we will ask them to provide additional information about the governance surrounding that arrangement in their **Professional Context Form**

|  |  |
| --- | --- |
| **Please respond to all the following statements by adding Yes (or No) in the column to the right** | |
| I believe the applicant has professional competence to undertake the Independent Prescribing and/or Advanced Clinical Assessment units |  |
| The student has the support of the organisation in which they are employed to complete the course and there is a recognised need for them to become/develop as a prescriber |  |
| The place of employment has sufficient indemnity arrangements to cover a trainee or developing prescribing pharmacist **or** we have checked that the applicant has sufficient indemnity arrangements to cover their training |  |
| **If** the applicant will be completing the clinical hours required in a different organisation to the one in which they are employed, I am satisfied this will be compatible with their role within their employing organisation. |  |

## **Section 6: Declaration of accuracy**

This declaration must be completed by the applicant’s manager, or another senior member of staff with responsibility for pharmacy education and training. I confirm that the information contained within this document is to the best of my knowledge and belief correct.

|  |  |
| --- | --- |
| Name |  |
| Role |  |
| Date |  |
| **When you have completed this form, please return it to the applicant so it can be upload to their online application. It forms an important part of the application and if it is incomplete, it may delay the processing, and potentially mean an offer cannot be made during this application round.** | |