PART C – PHARMACIST LISTING FORM

NHS Pharmaceutical Services – Enhanced Service
Independent prescribing for acute conditions service – TRANSITIONAL SERVICE

Pharmacist application form which is to be submitted to the Local Health Board (LHB) by a registered pharmacist requesting approval to provide the Enhanced Service – Independent prescribing for acute conditions service

To be completed by, or on behalf of, the pharmacist

LHB area in which the pharmacist predominantly intends to provide the service: (tick only one)

Swansea Bay University Health Board ☐
Aneurin Bevan University Health Board ☐
Betsi Cadwaladr University Health Board ☐
Cardiff and Vale University Health Board ☐
Cwm Taf Morgannwg University Health Board ☐
Hywel Dda University Health Board ☐
Powys Teaching Health Board ☐

Name of pharmacist: _____

General Pharmaceutical Council Registration number: _____

Correspondence address: _____

_____

Postcode: _____

Telephone number: _____

Email address (for NHS SSP use only): _____

Date of application: _____

Certifications, agreements and declarations

SECTION 1
I confirm that:
☐ I have completed all of the assessment activities and supervised practice requirements of a recognised independent prescriber training course;
☐ I have applied/commit to apply on confirmation of my successful course completion for my GPhC register entry to be annotated to reflect independent prescriber status
☐ I have a valid WCPPE Safeguarding Children and Young People Level 2 certificate
☐ I have successfully completed a Disclosure and Barring Service (DBS) check, or have made an application to do so, with NWSSP
☐ I have satisfied the authorised officers of the Local Health Board that I am competent in Antimicrobial Stewardship
☐ I enclose copies of the relevant certificates

SECTION 2
I confirm that:
☐ I agree to the details included in this form being included in the All Wales list of pharmacists approved to provide the service and that the NWSSP may disclose my accreditation status to pharmacy contractors by whom I am employed
☐ I agree to provide this service in accordance with the service specification
☐ I shall notify the Medical Director of the relevant LHB of any significant adverse incident which arises due to or related to provision of this service

Declaration

I declare that the information on this form and any evidence provided is correct and I seek acceptance as a provider of this Enhanced Service

Applicant signature: _____

Date: _____

Please submit this form to:
Primary Care Services
NHS Wales Shared Services Partnership
The Oldway Centre, 36 Orchard Street, Swansea, SA1 5AQ

or e-mail awpd@wales.nhs.uk or fax to 01792 607238/607394
For Office Use Only:

Application checked by:			Date:		
Request approved:		Yes	☐	No	☐
Initials and signature of person approving request:					
			Date:		
Reason if not approved:					
Name included in AWPD (if available)			Date:		