**Specialist Community Public Health Nursing (SCPHN)**

**Supplementary Information Form**

**To be completed by SELF EMPLOYED / SELF FUNDED APPLICANTS ONLY**

**To be completed in addition to your online application form**

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| --- | --- |
| **Applicant Details:** | |
| **Name:** |  |
| **Job Title:** |  |
| **Length of time in current role?**  ***Note: this is the role in which you will prescribe*** |  |
| **Describe your current role and area of practice:** |  |

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| --- | --- | --- | --- | --- | --- |
| **Nurse (level 1) or midwife:** | | | | | |
| **NMC registration no:** |  | | **No. of FULL years of post-registration experience (min 1 year post reg):** | |  |
| **Funding** | | | | | |
| **Please identity how you will fund your studies?** | |  | | | |
| **Have you ever applied for and commenced a programme of SCPHN preparation before?** | | | **Yes** | **No** | |
| **If Yes, please tell us the reason for non-completion** | | |  | | |
|  | | |  | | |

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| **SELF EMPLOYED STUDENTS MUST MAKE A DECLARATION IN ACCORDANCE WITH PROFESSIONAL RESPONSIBILITIES (NMC 2018)**  **Please answer YES or NO to confirm the following statements are correct:** | |
| **I have the ability to study at academic level 7:** |  |
| **I have identified a service need requiring me to undertake SCPHN training (please state if this is for Health Visiting or School Nursing):** |  |
| **Please briefly explain this service need:** |  |

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| --- | --- |
| **Please answer YES or NO to confirm that your employer has given commitment to the following:** | |
| **My attendance on this course:** |  |
| **Provision of continuing professional development/updating:** |  |
| **Provision of a SCPHN Practice Assessor:** |  |
| **Provision of a SCPHN Practice Supervisor:** |  |
| **Provision of a SCPHN placement (HV or SN):** |  |

**DECLARATION OF GOOD HEALTH AND GOOD CHARACTER**

***I declare that my health & good character is of a standard that enables me to deliver safe and effective practice:***

|  |  |
| --- | --- |
| **Full name:** |  |
| **Signature:** |  |
| **Date:** |  |

**DISCLOSURE AND BARRING SERVICES (Enhanced DBS) CHECK**

To be completed by your employer:

***I confirm that the applicant named above has undertaken an Enhanced DBS check within their current employment in the last year.***

*\* If no, please attach copy of DBS application as evidence that this has been applied for*

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| --- | --- |
| **Full name:** |  |
| **Signature:** |  |
| **Date:** |  |

**PRACTICE SUPPORT**

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| **Has a SCPHN Practice Supervisor (PS) and SCPHN Practice Assessor (PA) been identified? (yes/no)** |  |
| A minimum of 118 daysof supervised SCPHN (HV/SN) practice.  **The Practice Supervisor and / or Practice Assessor have a crucial role, which includes:**   * Establishing a supportive learning environment for the student * Facilitating learning through critical thinking and reflection * Providing dedicated time and opportunities for the student to observe how the Practice Supervisor / Practice Assessor delivers SCPHN HV or SN services * Allowing time for the student to carry out elements of SPCHN HV/Sn practice as discussed with the Practice Supervisor / Practice Assessor. * Allowing for the development and integration of theory and practice * Giving opportunities for in-depth discussion and analysis of clinical practice * Assessing and verifying that by the end of course the student is proficient in all required NMC SCPHN Proficiencies. | |
| **Please answer YES or NO to confirm the identified Practice Assessor (PA) has:** | |
| **Agreed to assess me on this course:** |  |
| **Is a registered SCPHN of same field with an additional level 7 academic qualification in teaching and assessing** |  |
| **Has the support of the Practice Assessors employer to undertake this role:** |  |
| **Agreed to engage with preparation and ongoing support sessions for SCPHN PA’s.** |  |
| **Please answer YES or NO to confirm the identified Practice Supervisor (PS) has:** | |
| **Agreed to supervise me on this SCPHN course:** |  |
| **Is a registered SCPHN of the same field, with at least ones years experience and completed preceptorship pack.** |  |
| **Has the support of the Practice Supervisors employer to undertake this role:** |  |
| **Agreed to engage with preparation and ongoing support sessions for SCPHN PS’s.** |  |

**SECTION A - To be completed by applicant:**

I do not have any conflict of interest with my Practice Assessor or Practice Supervisor

*(You must let us know of any conflict of interest ‐ for example, if they are a relative or you are in a relationship with them other than a professional working relationship)*

|  |  |
| --- | --- |
| **Full name:** |  |
| **Workplace contact details:**  *(Address, phone, email)* |  |
| **Signature:** |  |
| **Date:** |  |

**SECTION B - To be completed by SCPHN Practice Assessor:**

I have discussed the Practice Assessor role with the above candidate. I have the support of my employer to engage with this role and I agree to undertake the role and to access the preparation provided.

|  |  |
| --- | --- |
| **Full name:** |  |
| **Professional regulatory body:** |  |
| **Professional registration no:** |  |
| **Designation and professional qualifications:** |  |
| **Workplace contact details:**  *(Address, phone, email)* |  |
| **Signature:** |  |
| **Date:** |  |

**SECTION C - To be completed by SCPHN Practice Supervisor:**

I have discussed the Practice Supervisor role with the above candidate. I have the support of my employer to engage with this role and I agree to undertake the role and to access the preparation provided.

|  |  |
| --- | --- |
| **Full name:** |  |
| **Professional regulatory body:** |  |
| **Professional registration no:** |  |
| **Designation and professional qualifications:** |  |
| **Workplace contact details:**  *(Address, phone, email)* |  |
| **Signature:** |  |
| **Date:** |  |