Pharmaceutical Society NI

Protecting Registering Regulating

Application to register as a Pre-registration Trainee of the Pharmaceutical Society NI

ADDITIONAL SIX MONTHS TRAINING

DECISION TO ENTER PRE-REGISTRATION TRAINING DURING COVID-19

Applicants should make an informed decision about their health when deciding to enter pre-registration training during this period. You should understand the risks to your personal health. If you have an underlying health condition, which may place you at greater risk of severe illness if you were to catch COVID-19 you should seek medical advice in relation to applying for an additional period of pre-registration training.

All pre-registration trainees must follow the latest Government advice and follow the correct social distancing measures.

The completed application form must be submitted to the Pharmaceutical Society NI via email to: pre-registration@psni.org.uk.

INCOMPLETE APPLICATION FORMS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE APPLICANT.

An applicant should NOT start training until they have written confirmation from the Pharmaceutical Society NI that their application has been accepted.

NB For this period of additional 6 months training, the Standards for Pre-registration Training (Version November 2020) will apply. As tutors are now commonly referred to as 'Educational Supervisors', when reading the standards and completing this application please read the term tutor as 'Educational Supervisor' in line with the current terminology.

PERSONAL DETAILS

TITLE

SURNAME

FORENAMES
(**as on birth certificate**)

KNOWN AS

PREVIOUS SURNAME
(if applicable)

ADDRESS (Home)

TOWN/CITY

COUNTY

POSTCODE

HOME TEL NUMBER

MOBILE NUMBER

EMAIL ADDRESS

DATE OF BIRTH

DETAILS OF DEGREE

UNIVERSITY
(MPharm obtained from)
(OSPAP obtained from, if applicable)

DATE OF ENTRY TO DEGREE COURSE **(MM/YY)**

DATE OF GRADUATION **(MM/YY)**
(May be anticipated date)

HAVE YOU EVER UNDERTAKEN ANY PRE-REGISTRATION TRAINING IN GB? **YES** ☐ **NO** ☐
If you answer YES please provide FULL details below:

TRAINEE DECLARATION AND DATA PROTECTION STATEMENT

I declare that:

I wish to apply for an additional period of pre-registration training as a registered trainee of the Pharmaceutical Society NI.

I will abide by the Pharmaceutical Society's Code and I understand my obligations as detailed in the supplementary professional standards and guidance. I have read and understood and agree to adhere to the Pharmaceutical Society's Standards on Pre-registration Training.

I know of no reason that would prohibit me from continuing as a registered trainee of the Pharmaceutical Society NI.

I note the data protection statement below as it applies to relevant information held about me.

SIGNED *Handwritten signature required* **DATE**

PSNI Data Protection Statement

The Pharmaceutical Society NI (PSNI) is a data controller registered with the Information Commissioner's Office. We will make use of personal data provided to support our work in administering pre-registration training, as the regulatory body for Pharmacists and registered Pharmacies in Northern Ireland and for our work as the professional leadership body for Pharmacists in Northern Ireland. We will process your personal data for purposes including updating the trainee register, administering pre-registration training, registration, processing complaints, monitoring fitness to practise, and compiling statistics.

PSNI will not share your personal data on a commercial basis with any third party. We may, however, share your data with third parties to meet our statutory aims, objectives, powers and responsibilities under the Pharmacy (Northern Ireland) Order 1976, the regulations made under the Order and other legislation. Where appropriate we will share your information with organisations who have a legitimate interest including NICPLD, for the management of the foundation training year, the GPhC in relation to the common registration Assessment and other regulatory and enforcement authorities, Health and Social Care Board, Business Service Organisation, employers and the DoH as appropriate.

Your data is processed under the Data Protection Act 2018.
Your name, address, date of birth, telephone numbers, email address, employment details are used for the administration of the pre-registration training programme, finance and regulatory processing. These details are held securely in paper and digital form. By completing the application process, you agree to PSNI holding and processing these details under the Data Protection Act 2018.

Employment data can also be used to develop regulatory activities and services in relation to the workforce. This information, as a statistic, may be made publicly available.

Your personal details are used by departments dealing with pre-registration training, administration and communication to provide up to date information about pre-registration training, regulatory activities and by the Pharmacy Forum for the purpose of communications in relation to pre-registration training activities. This can be sent by postal mail or email and, under the Data Protection Act 2018, are sent under legitimate interests.

Declarations of health or character will be primarily processed by the Registrar and other members of the organisation for regulatory activities.

This information can be used in conjunction with FtP processes and can, where appropriate, be shared with relevant governing bodies. These are stored securely, in paper and digital form, separately from general registration data.

Your financial data is processed by the Business Manager and Finance Team. All data is securely stored in both paper and digital form and securely destroyed after 7 years in line with our Data Retention Schedule. You are entitled to see the information we hold about you. If you wish to see this information, please send your request in writing to: Data Protection Officer, Pharmaceutical Society NI, 73 University Street, Belfast BT7 1HL, detailing the information you wish to see. We are required to respond within 30 days.

PRE-REGISTRATION TRAINING PLACEMENT

NAME OF TRAINEE

NAME AND ADDRESS AT WHICH TRAINING WILL BE UNDERTAKEN

PREMISES NAME

ADDRESS

TOWN/CITY

POST CODE

TRAINING START DATE
(DD/MM/YY)

NAME OF ACCREDITED EDUCATIONAL SUPERVISOR

TELEPHONE NUMBER
(Premise)

NAME OF CONTACT
(if not employer)

EMPLOYER DETAILS – Community Pharmacy Placements

NAME OF TRAINEE

This section of the form must be completed by your prospective employer(s).

EMPLOYER DETAILS – Community Pharmacy Placements

NAME OF EMPLOYER

TRAINING START DATE
(DD/MM/YY)

TRAINING END DATE
(DD/MM/YY)

Please indicate the intended training programme by ticking the relevant box below

All training will be at the pharmacy premises indicated on page 3 ☐

EMPLOYER DECLARATION

This declaration must be completed by a pharmacist who has sufficient authority within the organisation to ensure that all Pharmaceutical Society NI requirements for pre-registration training will be met.

I confirm that the above named trainee has accepted an offer to undertake pre-registration training with the above name employer in the named premises.

I have read and understood and agree to adhere to the Pharmaceutical Society's Standards for Pre-registration training.

I confirm that a pharmacist meeting the Pharmaceutical Society's requirements for Educational Supervisors has agreed to act as an Educational Supervisor for the trainee for the specified period.

I note the data protection statement on Page 2 as it applies to relevant information held about me.

I confirm that the employing organisation will ensure that the correct right to work checks are completed before training begins and that appropriate visa arrangements will be in place for the duration of training if applicable.

SIGNED *Handwritten signature required*

DATE

PRINT NAME

POSITION IN ORGANISATION

NAME OF ACCREDITED EDUCATIONAL SUPERVISOR

EDUCATIONAL SUPERVISOR REGISTRATION NUMBER

EMPLOYER DETAILS – Hospital Pharmacy Placements
(PLEASE COMPLETE IN BLOCK CAPITALS)

NAME OF TRAINEE

This form must be completed by your prospective employer(s).

EMPLOYER DETAILS – Hospital Pharmacy Placements

NAME OF EMPLOYER

TRAINING START DATE
(DD/MM/YY)

TRAINING END DATE
(DD/MM/YY)

EMPLOYER DECLARATION

This declaration must be completed by a pharmacist who has sufficient authority within the organisation to ensure that all Pharmaceutical Society NI requirements for pre-registration training will be met.

I confirm that the above named trainee has accepted an offer to undertake pre-registration training with the above name employer in the named premises.

I have read and understood and agree to adhere to the Pharmaceutical Society's Standards for Pre-registration Training.

I confirm that a pharmacist meeting the Pharmaceutical Society's requirements for Educational Supervisors has agreed to act as an Educational Supervisor for the trainee for the specified period.

I note the data protection statement on Page 2 as it applies to relevant information held about me.

I confirm that the employing organisation will ensure that the correct right to work checks are completed before training begins and that appropriate visa arrangements will be in place for the duration of training if applicable.

SIGNED *Handwritten signature required* **DATE**

PRINT NAME

POSITION IN ORGANISATION

NAME OF ACCREDITED EDUCATIONAL SUPERVISOR

EDUCATIONAL SUPERVISOR REGISTRATION NUMBER

PREMISES ADDRESS
(where training will take place)

PREMISES POSTCODE

DETAILS OF EDUCATIONAL SUPERVISOR

NAME OF TRAINEE

This form must be completed by your Educational Supervisor*.

***If a Co-supervision arrangement is required please complete Page 7 & 8.**

EDUCATIONAL SUPERVISOR DETAILS

TRAINING START DATE
(DD/MM/YY)

TRAINING END DATE
(DD/MM/YY)

EDUCATIONAL SUPERVISOR SURNAME

REGISTRATION NO

EDUCATIONAL SUPERVISOR FORENAME(S)

PREMISES ADDRESS
(where training will take place)

PREMISES POSTCODE

PHARMACY EMAIL ADDRESS

TUTOR COURSE
(date last attended)
(DD/MM/YY)

EDUCATIONAL SUPERVISOR DECLARATION

1) I confirm that I have agreed to be the Educational Supervisor for the above named trainee in the above named premises for the dates indicated.
2) I have been in practice in this sector of pharmacy for a minimum of 3 years.
3) I have read and understood and agree to observe the Pharmaceutical Society's requirements and conditions for pre-registration Educational Supervisors as described in the current Standards for Pre-registration Training.
4) I confirm that I meet the requirements for Educational Supervisors (currently accredited).
5) I confirm that I am not the subject of any Fitness to Practise investigations or proceedings with any healthcare regulator
6) I confirm that I am compliant with the Pharmaceutical Society's Continuing Professional Development system.
7) I confirm that I will inform the Pharmaceutical Society NI if any of the above change during the dates indicated
8) I confirm that I am working in the above named premises a minimum of 30 hours over a minimum of 4 days each week
9) I note the data protection statement on Page 2 as it applies to relevant information held about me.

SIGNED /
Handwritten signature required

DATE

APPLICATION FOR A CO-SUPERVISION ARRANGEMENT

The preferred arrangement for supervision is that a single Educational Supervisor has a sole trainee for the duration of training. In exceptional circumstances, such as when an Educational Supervisor is unable to supervise a trainee for the requirement, of a minimum of 30 hours over a minimum of four days a week and when all other options for single supervision have been exhausted, a co-supervision arrangement may be considered where both Educational Supervisors share supervisory responsibilities. The trainee must consent to the co-supervision arrangement.

In a co-supervision arrangement, the aggregate hours worked by the Educational Supervisors must meet the minimum full-time requirement as described above. One supervisor will be nominated to conduct quarterly appraisals and to validate learning cycles via the reflective e-portfolio. Both supervisors in a co-supervision arrangement must co-sign the final declaration.

NAME OF TRAINEE:	

NAME OF FIRST EDUCATIONAL SUPERVISOR: ***(This supervisor will be nominated to conduct appraisals and validate the reflective e-portfolio)***	
REGISTRATION NUMBER:	

NAME OF SECOND EDUCATIONAL SUPERVISOR:	
REGISTRATION NUMBER:	

PREMISES ADDRESS: (where training will take place)	

The Pharmaceutical Society NI will check Educational Supervisor accreditation.

EDUCATIONAL SUPERVISORS' DECLARATION

We confirm that we have agreed to be the Educational Supervisors for the above named trainee in the above named premises

For the dates:

Starting: _____ dd/mm/yy **Ending**: _____ dd/mm/yy

1) We confirm that we have agreed to be the Educational Supervisors for the above named trainee in the above name premises for the dates indicated
2) We have been in practice in this sector of pharmacy for a minimum of 3 years
3) We have read, understood and agree to observe the requirements and conditions for Educational Supervisors as described in the current Standards for Pre-registration Training.
4) We confirm that we meet requirements for Educational Supervisors (currently accredited)
5) We confirm that we are not currently the subject of any fitness to practise investigations or proceedings with any healthcare regulator.
6) We confirm that I am compliant with the Pharmaceutical Society's Continuing Professional Development system.
7) We confirm that all other options for sole educational supervision have been exhausted.

8) We can confirm that the aggregate hours worked by both Educational Supervisors meets the requirement of a minimum of 30 hours over a minimum of 4 days each week

9) We confirm that we will inform the Pharmaceutical Society NI if any of the above change during the dates indicated.

10) We will both be responsible for co-signing the final declaration

11) We note the data protection statement on Page 2 as it applies to relevant information held about me/us.

FIRST EDUCATIONAL SUPERVISOR SIGNATURE:	*Handwritten signature required*
NAME:	
DATE:	

SECOND EDUCATIONAL SUPERVISOR SIGNATURE:	*Handwritten signature required*
NAME:	
DATE:	

TRAINEE DECLARATION

I consent to the co-supervision arrangement with the above named Educational Supervisors.

TRAINEE SIGNATURE:	*Handwritten signature required*
NAME:	
DATE:	

APPROVAL OF PHARMACY PREMISES AS A TRAINING ESTABLISHMENT

NAME OF TRAINEE

If training is to take place in two establishments, please provide details for both.

This section of the form should be completed by the employer or person within the organisation who has overall responsibility for pre-registration training.

A pharmacy approved for pre-registration training must provide an appropriate learning environment for the trainee.

Please tick to confirm the pharmacy owner/superintendent has:

		YES
1.	Sufficient staffing levels to allow appropriate learning to occur.	☐
2.	A suitably qualified Educational Supervisor who meets the requirements (currently accredited) available to supervise the trainee and when the Educational Supervisor is not available satisfactory arrangements will be in place.	☐
3.	Ensured that the trainee will have a minimum of 4 hours protected time to study: tailored to individual circumstances per working week.	☐
4.	Ensured that the premises have online internet access and the trainee is given access to the internet to aid training.	☐

Please state the **number of hours** to be worked by the trainee each week inclusive of protected study time. ☐

PREMISES NAME

PREMISES ADDRESS

POSTCODE

DATE

PRINT NAME **SIGNED** *Handwritten signature required*

Email your completed application to:
pre-registration@psni.org.uk

END OF APPLICATION FORM

Please check your application thoroughly

An applicant should NOT commence any period of training until they have written confirmation that their application has been accepted