

Collaborative Practitioners Prescribing Programme

Statement of Intent & Additional Information

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|  DIVISION OF GRADUATE MEDICAL STUDIESYONG LOO LIN SCHOOL OF MEDICINE |  |

NATIONAL UNIVERSITY OF SINGAPORE

**[1] CURRENT / INTENDED COLLABORATIVE PRESCRIBING PRACTICE**

**Please describe your participation in team-based care and prescribing-like activity in the past year (include start date, scope of practice and frequency).**

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**Please state your intended collaborative prescribing practice on completion of the course.**

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**[2] CLINICAL SUPERVISOR & RECOMMENDATION BY INSTITUTION**

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| **CLINICAL SUPERVISOR** (if a clinical supervisor has not yet been identified, please leave this blank) |
| Name, Designation and Department of Clinical Supervisor | Email |

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| **RECOMMENDATION BY HEAD OF DEPARTMENT (HOD) / MANAGER / SUPERVISOR** |
| I recommend and will support this applicant <Name> \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to attend the Collaborative Practitioners Prescribing Programme for the following reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name & Signature of HOD / Manager / Supervisor | Date |
| Designation | Email |

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| **SUPPORT FROM INSTITUTION LEADER** |
| My institution supports this applicant <Name> \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and will make available appropriate resources including, but not limited to, access to a Clinical Supervisor, peer and other supervisors, fees, work arrangement etc. to facilitate his/her completion of the Collaborative Practitioners Prescribing Programme. |
| Name & Signature of Institution Leader | Date |
| Designation | Email |

**[3] INSTITUTION BILLING DETAILS**

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| Contact person(s) |  |
| Phone No. |  |
| Email |  |
| Billing Address |  |
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Provide accurate information as your results will be withheld if you have outstanding fees at the end of the program

**[4] NEXT-OF-KIN (NOK) DETAILS**

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| Contact person(s) |  |
| Phone No. |  |
| Relationship with Applicant |  |