**Clinical Pharmacy Practice Programme**

**Declaration of Support from the Student’s Workplace**

*Note for the workplace*

The Clinical Pharmacy Practice Programme has been developed for practising pharmacists. The course learning materials, activities and assessments are designed to relate to actual pharmacy practice to make the student’s learning experience more meaningful to their own environment. As well as reflecting on their practice in relation to their own patients, students may require access to other data and need the support in their workplace to access this information. Students are advised that all information they use to help them complete their coursework should remain confidential and that no patients, prescribers, or other individuals should be named.

Prospective students must arrange for this Declaration Form to be completed by an appropriate person e.g. Line Manager, Superintendent Pharmacist or GP/Practice Manager and submit it with their course application.

Please complete the details below in BLOCK print.

Student’s Name: …………………………………………………………………………………………………

Name of Supporter: ………………………………………………………………………………………….....

Supporter’s Organisation/Address: ……..................................................................................................

…………………………………………………………………………………………………………………….

Telephone: ………………………………………….. Email address………………………………………..

Supporter’s Position in the Organisation: …………………………………………………………………....

How is this student being funded for their course? (Please Tick) Sponsor Self-funding Mix of Sponsor/Self-funding

If the above student is being Sponsored, please complete the following details:

Invoice Address (if different from above) …............................................................................................

…............................................................................................................................................................

Email address for invoice to be sent to: ….............................................................................................

Purchase Order Number (if known) ......................................................................................................

Amount of Sponsorship £ ......................................................................................................................

\**Please note that student tuition fees are reviewed each academic year and therefore may be subject to change*

**I agree to provide the support outlined above required to enable the** **above named student to complete their coursework for the Clinical Pharmacy Practice Programme**

Signature: ……………………………………………………………… Date: ……………………..