Application for the College of Mental Health Pharmacy

Foundation Certificate

This information will be treated as STRICTLY CONFIDENTIAL

Personal Details

|  |  |
| --- | --- |
| Mr / Ms / Mrs / Dr / Other: |  |
| Name: |  |
| HomeAddress: Telephone number:e-mail: |  |
| WorkAddress: Telephone number:e-mail: |  |
| Preferred mailing address: (please delete as applicable) | Home / Work |

Professional Details

Professional body name(s) (e.g. GPhC)

Year of professional registration(s):

Academic Qualifications:

Please give details of your qualifications (Degrees, diplomas etc.) with the name of the institution that awarded them and the date of the award.

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Courses completed for Foundation certificate eligibility:

To be eligible to apply, you MUST have completed at least TWO of the courses listed below within the last 3 years (one of which MUST be Psych 1 OR Psych 2).

|  |  |
| --- | --- |
| Course name | Date completed (if applicable) |
| Psych 1 (CMHP) |  |
| Psych 2 (CMHP) |  |
| Part 1 -Drugs (RCGP) |  |
| Part 1 -Drugs Recert (RCGP) |  |
| Part 1 -Alcohol (RCGP) |  |
| Any clinical certificate module (BAP)(specify which): |  |

*See the website for more information:*

<https://www.cmhp.org.uk/expertise/credentialing/foundation-certificate/>

Employment History:

|  |  |  |
| --- | --- | --- |
| Date (to-from) | Employer | Job Title |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

References

Please provide the names, addresses and telephone numbers of two references (one of who must be qualified pharmacist or pharmacy technician) that support your application to apply for the CMHP Foundation Certificate. These referees will be contacted on submission of your application form.

|  |  |  |
| --- | --- | --- |
|  | Referee one | Referee two |
| Title |  |  |
| Name |  |  |
| Address |  |  |
| Email |  |  |
| Telephone |  |  |

Notification of successful outcome

If you are successful in achieving the Foundation Certificate, it is the intention for the College to write to senior members of your employment organisation. Please state below whom you would like the Registrar to write to (usually your chief pharmacist/line manager).

Signature:

☐ I am happy to be contacted by the CMHP in regards to supporting other staff who are undertaking or considering undertaking the foundation certificate.

☐ I consent to the CMHP keeping a secure record of my application and associated documents for internal record keeping and governance purposes. This record will not be shared or used for any other purposes.

Date:

Declaration:

I confirm that I understand the Foundation Certificate fee of £100 is payable at the time of application and not refundable except at the discretion of the CMHP registrar/council who may consider extenuating circumstances if applicable.

|  |  |  |
| --- | --- | --- |
|  | Notification one | Notification two |
| Title |  |  |
| Name |  |  |
| Address |  |  |
| Email |  |  |
| Telephone |  |  |

Your **completed application form should be sent** to info@cmhp.org.uk and registrar@cmhp.org.uk

Payment should be made to CMHP

Account Name: College of Mental Health Pharmacy

Sort Code: 40-35-34

Account Number: 92722348

Reference: Your Name

If you require an invoice for your employer to fund the certificate you will need to raise a purchase order and an invoice can be generated on receipt.

Your application will not be progressed until payment has been received.

**Please indicate if you would prefer an online (“virtual”) or in person Viva (**in person will only be able to take place in October at the Annual CMHP conference)

|  |  |
| --- | --- |
|  | Preference  |
| Online |  |
| Virtual |  |