|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| NAME |  | | | | | |
| JOB ROLE |  | | | | | |
| PRACTICE |  | | | | | |
| PCN |  | | | | | |
| EMAIL ADDRESS |  | | | | | |
| PRACTICE MANAGER’S EMAIL ADDRESS | | |  | | | |
| Do the practice agreed to the contribute £250 towards the GPN Preceptorship? | | | | | Yes  No | |
| What are your personal objectives in applying to this programme? | | | | | | |
|  | | | | | | |
| DO YOU HAVE SERVICE AREA AGREEMENT TO SUPPORT WORKBASED LEARNING OPPORTUNITIES RE TIME AND SUPERVISION?  Typically one day per month released from role during course | | | | | Yes  No | |
| **I understand that if I am accepted on this programme, I will need to commit to attending all sessions, including training days, as needed.**  **I confirm that:**   1. **If I secure and confirm a place on this scheme a contribution of £250 will be paid.** 2. **the information given in this form is accurate and is consistent with the criteria of the GPN Preceptorship Programme and that information contained in this form will be shared with NHS England for the purposes of monitoring the programme.** | | | | | | | |
| Name of GPN | |  | | | | | |
| Signature | |  | | Date | |  | |
| **On behalf of the employing practice, I confirm that the GPN is currently employed by the practice.** | | | | | | | |
| Name of authorising employer (e.g. practice manager) | |  | | | | | |
| Signature of authorising employer (e.g. practice manager) | |  | | Date | |  | |