|  |  |
| --- | --- |
|  |  |

**Application to access CPD funding for Registered Nurses & AHPs in General Practice**

**Please email a signed copy of this form to** [**Kernowhealthcic.workforce@nhs.net**](mailto:kernowhealthcic.workforce@nhs.net?subject=CPD%20funding%20request) **with the subject “CPD Funding request”**

**Your Details**

|  |  |
| --- | --- |
| Name |  |
| Employing Practice |  |
| Employment start date |  |
| Profession |  |
| Professional Registration Number |  |

**Please tell us about the CPD you are accessing this funding for**

|  |  |
| --- | --- |
| Name of course |  |
| Name of the Provider (e.g., university name) |  |
| Proposed start date of course |  |
| Cost of the course |  |

|  |  |
| --- | --- |
| Have you already undertaken or been accepted for a funded place on any University course since April 2020? |  |
| If yes, please tell us which course  *e.g., Non-medical prescribing, Advanced practice module, condition specific module* |  |

|  |
| --- |
| Please give us further details about the CPD you are requesting funding for, including how it links to your personal development plan, and practice population health needs. We will use this information for reporting against the funding |
|  |

**Applicant Declaration**

I can confirm that I would like to access CPD funding for Registered Nurses and AHPs and that the above information is correct. The CPD I would like to undertake has been discussed with my practice manager and agreed forms part of my personal development plan and practice priorities.

Signature of applicant

Name of Applicant

Date of Application

**Practice Authorisation**

I confirm, as Practice Manager, that I authorise the use of the CPD funding for Practice Nurses and AHPs for the above. The CPD to be undertaken is part of the personal development plan of this member of staff and aligns to the priorities of the practice. I understand that if this request exceeds £330 in any 12-month period, this may impact the amount of funding available to other members of staff within the practice for this period.

Signature of Practice Manager or Partner

Name

Role in the Practice

Date