**\*\*THE FOLLOWING SECTION IS TO BE COMPLETED BY THE APPLICANT\*\***

This Certificate is required by applicants applying to enrol on to the Pharmaceutical Medicine Specialty Training (PMST) programme at ST3 level.

**When using this Certificate, please note:**

* You will be required to submit your completed Certificate with your completed Associate (Trainee) Membership & Pharmaceutical Medicine Specialty Training Application Form, so it is advised that you prepare your documents in advance.
* The signatory to this Certificate can only be either:
* a Consultant / specialist
* a GP supervisor, or
* your prospective Educational Supervisor (ES) in pharmaceutical medicine who has been approved by the GMC.
* The Consultant or ES are only eligible to sign this Certificate if you have worked with or for them for a minimum continuous period of 3 months within the 5 years prior to your application to enrol on to PMST.
* You must have signed off at least **42 of the 52 competencies** listed in this Certificate. The signatory must have witnessed personally your achievement of the competency or enter the initials of a colleague who has done so by the time you apply. You must have all the competencies highlighted pink signed off as these are key competencies. If you cannot demonstrate that you have achieved all your outcomes from one signatory, you may submit additional Certificates to demonstrate the full set of outcomes.
* The Certificate **must** be completed in every detail, including details of the signatories. Incomplete Certificates may lead to your application being ineligible for enrolment on to PMST. It is strongly recommended that you check the form after the signatory has completed it using the checklist at the end of the form.
* Only this version of the Certificate is accepted.

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| **Applicant to complete this section and sign declaration:** | |
| I confirm that I have attained the competencies signed off in this form, and that I have worked with or for the consultant, GP supervisor or prospective ES for a minimum continuous period of 3 months (whole time equivalent) within the 5 years prior to applying to enrol on to PMST. | |
| **Applicant full name:** |  |
| **Applicant GMC number:** |  |
| **Applicant signature:** |  |

**\*\*THE FOLLOWING SECTION IS TO BE COMPLETED BY THE SUPERVISING CONSULTANT / GP SUPERVISOR / PROSPECTIVE EDUCATIONAL SUPERVISOR IN PHARMACEUTICAL MEDICINE\*\***

The person who has asked you to fill in this form is applying to enrol on to the Pharmaceutical Medicine Specialty Training (PMST) programme at ST3 level in the United Kingdom (UK). To process their application, we need to know that they have achieved the competencies listed in this certificate. Applicants need to have demonstrated at least **42 of the 52 listed competencies**, which must include all the **key competencies**, to progress. The key competencies are highlighted pink.

**When using this Certificate, please note:**

* The doctor must have worked with or for you for a minimum continuous period of 3 months within the 5 years prior to applying to enrol on to PMST.
* Only sign the competencies that you can confirm. You do not need to have personally witnessed all competencies but should be satisfied that any you sign off has been achieved and that there is no reason why these competencies are in doubt or should prevent enrolment on to PMST at ST3 level. Examples of how you can satisfy yourself about attainment of competencies include:
  + your own observation of them
  + confirmation from another supervisor that the applicant possesses the competencies
  + viewing their trainee or revalidation e-portfolio (for those maintaining them)
* Any competencies claimed to have been acquired during a core training/Acute Care Common Stem-Acute Medicine (ACCS-AM) programme must be evidenced within the e-portfolio. Alternative evidence of competencies achieved and demonstrated after leaving the core training programme must be provided for any which are not recorded in the e-portfolio.
* Applicants can obtain additional Certificates for competencies that you are unable to sign off.
* This Certificate must be completed correctly, including your details. Failure to complete it fully may render the applicant ineligible to be considered further for enrolment on to PMST.
* You must sign and date each page of this form individually.
* Please include up-to-date contact details should we need to verify any of the competencies prior to or after the applicant’s enrolment.

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| APPLICANT NAME: | DATE OF COMPLETION: |

APPLICANT NAME DATE OF COMPLETION

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| **About the person signing the Certificate:** | |
| **Your name:** |  |
| **GMC No (if applicable):** |  |
| **Professional status:** |  |
| **Current post:** |  |
| **Address for correspondence:** |  |
| **Email address:** |  |
| **Contact telephone number:** |  |
| If you are not registered with the UK General Medical Council please give: | |
| **Name of your registering body:** |  |
| **Your registration number:** |  |
| **Website address where this information can be verified:** | www.     . |
| Alternatively, you may attach photocopy evidence of your professional status to this Certificate. | |
| **About how you know the applicant and their work:** Please give details of the post this applicant held at the time when you observed their work. | |
| **Applicant specialty and level** |  |
| **Dates post held (from/to)** |  |
| **Name of hospital, GP surgery or pharmaceutical organisation** |  |
| **Country** |  |

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| APPLICANT NAME: | DATE OF COMPLETION: |

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| **About the applicant’s demonstrable competencies:** | | | | |
| Please complete one of the three boxes on the right-hand side for **ALL** competencies as follows:   * Tick the box for those competencies you have **witnessed** **personally** and those which you are **unable to confirm**. * Enter the **initials** of your colleague in the corresponding column where you are signing off a competency you have **not witnessed personally**. If this is via reviewing an ePortfolio, please initial it with ‘EP’. | **Witnessed personally** | **Initials of witnessing colleague** | **Unable to confirm** |
| **1. Professional Competencies** | | | | |
| **1.1 Professional values and behaviour** | | | | |
| (i) Able to demonstrate knowledge of, and to practise appropriate procedures for valid consent. |  |  |  |
| (ii) Able to use resources effectively for patient benefit. |  |  |  |
| (iii) Able to show initiative and resilience to cope with changing circumstances. |  |  |  |
| (iv) Able to demonstrate the ability to work effectively in the face of uncertainty. |  |  |  |
| (v) Able to demonstrate the capacity to take responsibility for own actions. |  |  |  |
| (vi) Able to demonstrate a non-judgemental approach to others and show a respect for all. |  |  |  |
| (vii) Able to demonstrate that s/he understands the effects of health inequality on public health and recognises effective health promotion. |  |  |  |
| **1.2 Professional capabilities** | | | | |
| (i) Evidence of time management and prioritisation in decision-making. |  |  |  |
| (ii) Able to demonstrate the knowledge, skills and behaviours to be able to communicate effectively with patients, relatives and colleagues in the circumstances outlined below:   * Within a consultation * Breaking bad news * Complaints and medical error |  |  |  |
| (iii) Able to demonstrate the knowledge, skills, and behaviours to be able to educate patients effectively to reduce ill health. |  |  |  |
| (iv) Able to demonstrate the capacity to work effectively under pressure. |  |  |  |
| (v) Able to demonstrate the ability to communicate effectively with colleagues and the wider multidisciplinary team. |  |  |  |
| (vi) Able to demonstrate clarity in written and spoken communication, and a capacity to adapt language to the situation as appropriate. |  |  |  |
| (vii) Able to demonstrate basic information technology skills. |  |  |  |
| (viii) Capacity to demonstrate an analytical / scientific approach to solve problems and to make decisions. |  |  |  |

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| **1.3 Professional knowledge** | | | | | | | | | | |
| (i) Able to demonstrate a knowledge of the legal framework for medical practice in the UK. | | |  |  | | |  | | |
| (ii) Understands, respects and demonstrates the values of the NHS Constitution. | | |  |  | | |  | | |
| **1.4 Capabilities in leadership and teamwork** | | | | | | | | | |
| (i) Demonstrate the ability to work effectively with colleagues as a team that best serves patients’ interests. | | |  |  | | |  | | |
| (ii) Able to demonstrate ability to always practise with probity in a professional and non-discriminatory manner in situations concerning:   * Doctor-patient relationships * Health and personal stress * Patients, colleagues and others | | |  |  | | |  | | |
| (iii) Evidence of involvement in the management of people or projects commensurate with experience. | | |  |  | | |  | | |
| (iv) Evidence of effective multi-disciplinary team working and capacity to work with others. | | |  |  | | |  | | |
| (v) Evidence of effective leadership in medicine. | | |  |  | | |  | | |
| (vi) Ability to demonstrate awareness of the limits of his or her competence and when to request senior or more experienced help. | | |  |  | | |  | | |
| (vii) Able to demonstrate ability to work without direct supervision where appropriate. | | |  |  | | |  | | |
| **1.5 Capabilities in patient safety and quality improvement** | | | | | | | | | |
| (i) Ability to demonstrate the knowledge, skills and behaviours to teach and train other healthcare professionals. | | |  | |  | | |  | |
| (ii) Ability to demonstrate being open to feedback and valuing appraisal. | | |  | |  | | |  | |
| **1.6 Capabilities in research and scholarship** | | | | | | | | | |
| (i) Able to demonstrate that s/he understand the elements of clinical governance. | |  | | | |  | | |  |
| (ii) Able to demonstrate the use of evidence and evidence-based guidelines in clinical practice. | |  | | | |  | | |  |
| (iii) Ensures that research is undertaken in accordance with medical ethics and confidentiality. | |  | | | |  | | |  |
| (iv) Ability to demonstrate an understanding of basic research methodology. | |  | | | |  | | |  |
| Verifying signature of:  - Consultant, or  - GP supervisor, or  - Educational Supervisor  confirming details above. |  | | | | | | | | |

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| APPLICANT NAME: | DATE OF COMPLETION: |

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| **2. Clinical competencies** | | | | |
| **2.1 Clinical capabilities** | | | | |
| (i) Able to take a focussed and accurate history. | |  |  |  |
| (ii) Able to perform a focussed and accurate clinical examination. | |  |  |  |
| (iii) Able to demonstrate the application of therapeutic principles to safe prescribing and monitoring of the effects of medicines. | |  |  |  |
| (iv) Able to demonstrate diagnostic decision-making and clinical reasoning. | |  |  |  |
| (v) Experience in managing long term conditions in a variety of settings and age groups, promoting patient self-care. | |  |  |  |
| (vi) Able to demonstrate the knowledge, skills and behaviours to be able to manage acute presentations. | |  |  |  |
| (vii) Able to demonstrate prompt assessment and management of the acutely ill or collapsed patient. | |  |  |  |
| (viii) Able to demonstrate appropriate decision-making and clinical reasoning. | |  |  |  |
| (ix) Evidence of reassessing ill patients appropriately after starting treatment. | |  |  |  |
| (x) Ability to identify, assess, initiate resuscitation and manage cardio-respiratory arrest. | |  |  |  |
| (xi) Ability to identify, assess and initiate immediate management of a shocked patient. | |  |  |  |
| (xii) Ability to identify, assess, monitor appropriately, investigate and initiate the management of the unconscious patient. | |  |  |  |
| (xiii) Ability to identify, assess, initiate resuscitation and management of anaphylactic shock. | |  |  |  |
| (xiv) Able to interpret haematological, biochemical and radiological investigations. | |  |  |  |
| **2.2 Capabilities in patient safety and quality improvement** | | | | |
| (i) Prioritises patient safety, understands risk and mechanisms for reporting adverse incidents. | |  |  |  |
| (ii) Able to demonstrate understanding of the concepts of audit and quality improvement and their application in practice to benefit patient care. | |  |  |  |
| (iii) Evidence of self-reflective practice. | |  |  |  |
| **2.3 Clinical values and behaviours** | | | | |
| (i) Able to demonstrate taking prompt action if s/he thinks that patient safety, dignity or comfort is being compromised. | |  |  |  |
| (ii) Able to show a commitment in clinical practice to working in partnership with patients to improve their lives. | |  |  |  |
| (iii) Able to demonstrate treating all patients equally, as individuals, with compassion and respect for their dignity. | |  |  |  |
| (iv) Able to demonstrate prioritising the patient’s wishes, beliefs, expectations and needs. | |  |  |  |
| (v) Evidence of having considered the appropriateness of interventions according to patients’ wishes, severity of illness and chronic or co-morbid diseases. | |  |  |  |
| Verifying signature of:  - Consultant, or  - GP supervisor, or  - Educational Supervisor  confirming details above. |  | | | |

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| APPLICANT NAME: | DATE OF COMPLETION: |

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| **Declaration by the person signing this Certificate:**  **Reminder:** We wish to remind signatories of their professional responsibilities under paragraph 71 of the UK General Medical Council’s guidance ‘Good Medical Practice’, which states that: “You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.” **Failure to do so renders you, the signatory, at risk of being referred to your regulatory authority (the GMC or equivalent)**. Patient safety must remain your primary concern. | | |
| **Applicant’s full name:** | |  |
| A)  I confirm that the doctor named above has worked for or with me for a minimum of 3 continuous months (whole time equivalent) within the 5 years prior to applying to enrol on to the PMST programme. | | |
| B)  I confirm that I have observed the doctor named above demonstrate all the above competencies that I have signed, or where I have not personally observed them, I have received alternative evidence that I know to be reliable. | | |
| **NB:** *This form is invalid unless both boxes above are checked.* | | |
| **Verifying signature of:**  **- Consultant, or**  **- GP supervisor, or**  **- Educational Supervisor** |  | |
| **Full name of verifying:**  **- Consultant, or**  **- GP supervisor, or**  **- Educational Supervisor** |  | |
| **Date** |  | |
| **Hospital, GP surgery or pharmaceutical organisation stamp**  If not available, please attach a signed compliment slip, giving hospital, GP surgery or pharmaceutical organisation name and website address |  | |

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| **List of people whose evidence I have used in signing this Certificate**  Please ensure that you have entered the initials of the individual (or e-portfolio where relevant) against each of the competencies they have witnessed in that section of the form. **Please note that, as part of the verification process, witnesses may be contacted to verify and confirm that they have provided you with such evidence.**  **Declaration:** Where I have not personally observed them, I have received alternative evidence that I know to be reliable from either:   * a colleague who is working satisfactorily as a senior trainee (i.e. at UK level ST5\* or above) or higher, as detailed below. * Via the JRCPTB e-portfolio for core medical training   \*See JRCPTB website for information about what constitutes ST5 in the UK: <http://www.jrcptb.org.uk/specialties>  If necessary, please add witnesses to an additional copy of this page: | | |
| **E-portfolio: If the applicant has maintained an ePortfolio to track core medical competencies and you have used it to help complete this form, please tick this box:** | |  |
| **Witness 1:** | | |
| **Their name:** |  | |
| **Professional status:** |  | |
| **Work address:** |  | |
| **Email address:** |  | |
| **Witness 2:** | | |
| **Their name:** |  | |
| **Professional status:** |  | |
| **Work address:** |  | |
| **Email address:** |  | |
| **Witness 3:** | | |
| **Their name:** |  | |
| **Professional status:** |  | |
| **Work address:** |  | |
| **Email address:** |  | |
| Signature of verifying Consultant / GP supervisor / Educational Supervisor confirming details above: |  | |

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| APPLICANT NAME: | DATE OF COMPLETION: |

**CHECKLIST FOR APPLICANTS SUBMITTING CERTIFICATE OF COMPETENCIES**

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| **Page 1** | **Tick if complete** |
| 1. Have you added your name and GMC number in the relevant boxes of the applicant declaration section?  2. Have you signed the applicant declaration? |  |
| **Page 3** | **Tick if complete** |
| 3. Has the Consultant, GP supervisor or Educational Supervisor you have asked to sign the Certificate filled in their details correctly:   1. name 2. professional status 3. current post 4. address for correspondence 5. email address and contact telephone number 6. GMC number or if not registered with the UK GMC, the name of the registration body and their registration number |  |
| 4. Have they told us how they know you?   1. specialty and level of the post to which this Certificate relates 2. start and end dates of the post in which they worked with you 3. name and country of the hospital in which the post was based |  |
| **Pages 4 to 7** | **Tick if complete** |
| 5. Has the Consultant, GP supervisor or Educational Supervisor signing this Certificate signed at least 42 of the competencies, which must include the key competencies highlighted in pink? If not, and a competency has not been confirmed, have you obtained another form from another Consultant, GP supervisor or Educational Supervisor (meeting the criteria) providing evidence of competency?  6. Where a competency has not been witnessed personally by the signatory, have they provided the initials of the witnessing colleague for all relevant competencies? |  |
| **Page 8** | **Tick if complete** |
| 7. Have they put your name in the box at the top?  8. Have they ticked boxes A and B?  9. Have they signed the declaration and provided all their details requested?  10. Is there a hospital, GP surgery, pharmaceutical organisation stamp or accompanying compliment slip? |  |

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| **Page 9** | **Tick if complete** |
| 11. Has the signatory listed everyone whose evidence they relied upon for any of the competencies? |  |
| **Page 2 to 9** | **Tick if complete** |
| 12. Is your name (i.e. “Applicant’s Name”) added to the foot of each page, together with the date of completion of the form? |  |

**If the answer to any of the above questions is “No”, then your Certificate may be rejected, and you may be deemed not to have demonstrated that you have achieved the competencies.**

Please keep a copy of this Certificate for your own records.

**PLEASE ENSURE THAT YOU ATTACH A COPY OF THIS CERTIFICATE TO YOUR ASSOCIATE (TRAINEE) MEMBERSHIP & PMST APPLICATION FORM BEFORE SUBMISSION.**