

NATIONAL COLLABORATIVE PRESCRIBING PROGRAMME
CLINICAL SUPERVISOR FINAL REPORT

In my capacity as Clinical Supervisor, I am satisfied that(trainee's name)
from (department, institution) has completed the National
Collaborative Prescribing Programme Clinical Practicum successfully and is ready to sit for the
summative assessments.

I understand that upon successful completion of the summative assessments, he/she will be awarded
a Certificate of Successful Completion of the National Collaborative Prescribing Programme and is
eligible to apply for collaborative prescribing privileges in my institution as stated in the Collaborative
Practice Agreement.

Clinical Supervisor's name:

Name stamp:

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Signature:

Date:

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