Graphical user interface, text, application

Description automatically generated**DECLARATION FORM**

**To be signed by the Applicant, Director of Nursing, Nurse Manager, and Clinical Competence Assessor.**

Module Title:  **National Foundation Education Module in Critical Care Nursing**

Student’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(as on the Nursing and Midwifery Board of Ireland Register)

Student’s NMBI number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what capacity do you work? Job Share\_\_\_\_\_\_\_ Part time\_\_\_\_\_\_ Full time\_\_\_\_\_\_\_\_\_

If Part-time/Job Sharing, how many hours per month do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you engaged in day and/or night duty? Day\_\_\_\_\_\_\_\_\_\_\_\_\_ Night\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Students must be engaged in relevant clinical practice for a minimum of 75 hours per month for the programme they have applied for.

**Applicant Declaration of Understanding  
I understand that any financial support made available to me for my programme of study will be subject to the following conditions:**

* As per HSE HR Circular 020/2014 page 2 point 3, ‘successful applicants for sponsorship will be required to give a written undertaking to their employing public health service agency that they will, following successful completion of the programme, work for their employing agency for a minimum period of twelve months or for the length of the academic course undertaken, whichever is longer.’
* I shall be liable to repay the programme fees to the HSE (employing public health service agency) if:
  + I do not complete my programme
  + After the completion of my programme, I cease working in my employing public health service agency and have not worked for a minimum period of 12 months or for the length of the academic course undertaken, whichever is longer or
* I understand that no funds will be provided for repeat modules, units of study, or deferrals. Such fees will be borne by me.
* I understand that my personal data will be processed between the HSE and Third Party (Higher Education Institute) for the purpose of performance monitoring against the contract and compliance with HSE HR Circular 020/2014.

**I agree with all the above.  
Signature of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Line Manager Declaration (or delegated authority authorised by DON/M)**

**I have held a discussion with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ regarding this application.**

**I (a) am satisfied that the applicant fulfils the service requirement for this sponsorship as per HSE HR Circular 020/2014 and funding approved by the ONMSD and (b) agree to monitor and action any non-compliance as per HSE HR Circular 020/2014.**

Name *(in block capitals)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Director of Nursing Declaration**

I (Director of Nursing/Midwifery) verify that the above-named student is currently engaged in nursing/midwifery practice relevant to the programme and will be supported by the hospital to receive the necessary clinical experience required to successfully complete the programme.

**PRINT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Director of Nursing/Midwifery

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Employment Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area of Clinical Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Competence Assessor Nomination**

Criteria:

Registered nurse with professional qualifications appropriate to the speciality.

Have at least two years of experience in the area of specialist nursing practice.

Have completed preceptor training. This can be attained via HSELand.

Prior experience in assessing student learners is desirable.

Name of Assessor (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessor’s Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessor’s Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessor’s E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for agreeing to support this applicant to complete their programme of study.