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| Swansea University RFC - Image: www.pitchero.com  **Swansea University**  **Prifysgol Abertawe** |

##### Please select ONE of the following: Please complete in BLOCK CAPITALS

**Full Time Part Time**

**• Public Health and Specialist Community Public Health** **Nursing**

**Health Visiting**  **School Health Nursing**

**• Community Health Studies (Specialist Practice Award)**

**District Nursing**

**Grad Diploma**  **BSc**  **PG** **Diploma**  **MSc**

Have you previously studied at Swansea University? YES/NO If yes, **student number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### **PERSONAL DETAILS**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: *Mr/Mrs/Miss/Ms/Other* Other Name (Known as): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Surname(s)/Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Home address: | | Correspondence address: dates to/from | |
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| Post code: | Tel: | Post code: | Tel: |

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Welsh Speaking: YES/NO

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please check your inbox and junk inbox for updates)

PIN NUMBER: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Registration Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### **NMC REGISTRATION DETAILS**

Part 1 – Nursing Specialist/Branch

Part 2 – Midwifery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part 3 – Specialist Community Public Health Nursing

Please specify specialist/branch in which you practice e.g. children’s nursing, mental health nursing, school health nursing, practice nursing, ITU etc.

###### **PROFESSIONAL QUALIFICATIONS**

**PROFESSIONAL HEALTH EDUCATION QUALIFICATIONS *(Please include copies of your certificates).***

**NMC Registered Professional Qualifications and year obtained**

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| Date | Name of Qualification | Awarding Board | Level | Subject | CATS Points |
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###### **ACADEMIC QUALIFICATIONS ( please include copies of your certificates)**

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| Date | Examination Board | Level e.g Cert,Dip,Degree | Subject | Classification |
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###### **APPROPRIATE STUDY DAYS**

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| Title of Course | From Month/Year | To Month/Year | Qualification Obtained |
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###### **EMPLOYMENT HISTORY most recent first**

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| Name and Address of Employer | From | To | Department/Ward/Place of work and Position Held |

###### **REFERENCES**

Please note below the names and addresses of two persons who would support your application

**(Line Manager and an Academic Referee)**

1. Name of first referee (Line Manager): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Email address (this is essential): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name of second referee (Academic): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For those applying for the Health Visiting and District Nursing programme that has an integrated nurse-prescribing component you will need to consider and agree with the following statement. I understand the responsibility and demands required of an individual in order to safely and competently prescribe from within the community formulary (V100). I confirm that I am able to undertake a holistic assessment and make effective judgements in terms of individualised clinical decisions and/or clinical diagnosis; so that following completion of the prescribing module I am capable of demonstrating safe and effective prescribing practice. I am aware that I will not be able to prescribe until successful completion of the professional award (SCPHN or SPDN)

Applicant signature: Date:

**Please briefly describe your present job, work setting and outline your reasons for wishing to undertake your chosen programme of study. You can complete below or attach a word document with the additional information.**

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***If you have any special learning needs or other disability, you are advised to contact the University Disability Office so that reasonable adjustments can be assessed.***

*WHERE DID YOU HEAR ABOUT THE COURSE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that the information provided on this application form is true, complete and accurate, and that no information requested or other material information has been omitted. I understand that the University reserves the right to establish the authenticity of my application and that it reserves the right to cancel my application if it transpires that false information has been provided. I also understand that a place on the course will be subject to a satisfactory medical examination and an enhanced DBS check.

**PLEASE RETURN THIS COMPLETED FORM BY E-MAIL TO:**

Recruitment and Selection Team email: [chhsadmissions@swansea.ac.uk](mailto:chhsadmissions@swansea.ac.uk)