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**Return to Nursing/Midwifery Practice Programme (RTNMP)**

**Expression of Interest Form**

**PLEASE COMPLETE THIS FORM IN BLOCK CAPTIALS**

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| **PERSONAL DETAILS** | |
| **SURNAME** |  |
| **FIRST NAME** |  |
| **MAIDEN NAME (IF APPLICABLE)** |  |
| **ADDRESS** |  |
| **DATE OF BIRTH** | DD / MM / YYYY |
| **CONTACT PHONE NUMBER** |  |
| **MOBILE NUMBER**  **(IF DIFFERENT FROM ABOVE)** |  |
| **PERSONAL EMAIL ADDRESS** |  |

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| **NMBI REGISTRATION DETAILS** | |
| **NAME AS ON REGISTER** |  |
| **NMBI PIN** |  |
| **ANY FITNESS TO PRACTICE ISSUES** |  |

* **Active NMBI Registration:** enclose a copy of your NMBI registration with this application
* **Inactive NMBI Registration:** see page 6 of NMBI RTN/MP Standards and Requirements:

***Nursing****:* <https://www.nmbi.ie/NMBI/media/NMBI/Return-to-Nursing-Practice-Programmes-Standards-and-Requirements.pdf?ext=.pdf>

***Midwifery:*** <https://www.nmbi.ie/Education/Standards-and-Requirements/Return-to-Midwifery-Practice>

* ***See more at*** <http://www.nmbi.ie/Registration/the-Register-and-Divisions#sthash.lFXN6312.dpuf>

**Please indicate which registrations you hold with NMBI and date of registration**

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| **Designation Titles** | **Abbreviation** |  | **Registration Date** |
| Registered General Nurse | RGN |  |  |
| Registered Midwife | RM |  |  |
| Registered Children's Nurse | RCN |  |  |
| Registered Psychiatric Nurse | RPN |  |  |
| Registered Nurse Intellectual Disability | RNID |  |  |
| Registered Public Health Nurse | RPHN |  |  |
| Registered Nurse Tutor | RNT |  |  |
| Registered Nurse Prescriber | RNP |  |  |
| Registered Advanced Nurse Practitioner | RANP |  |  |
| Registered Advanced Midwife Practitioner | RAMP |  |  |

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| **Have you previously completed a Return to Nursing/ Midwifery Practice Programme?** | | |
| **YES** | | **NO** |
| **If yes, please answer the questions below** | | |
| **Date Completed** | DD / MM / YYYY | |
| **Location of the Programme** |  | |
| **Division of nursing/ midwifery e.g. RGN/RM/RNID/RCN/RPN** |  | |
| **Did you receive the HSE Bursary?** |  | |
| **Did you take up employment after completing the programme?** |  | |
| **If so, where?** |  | |

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| How many years/months are you out of Nursing/Midwifery Practice? |  |
| Please indicate the division (**ONLY ONE**) of the NMBI register in which you are applying for the Return to Nursing/ Midwifery Practice Programme 2023 | * RGN * RM * RCN * RPN * RNID |
| Please indicate the region/hospital that you are interested in working in *on successful completion of the RTNMP programme* |  |

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| **Please indicate your preferred location for undertaking the Return to Practice Programme**  (please rank in order of preference i.e. 1 is preferred location) | |
| **HSE Dublin North East** |  |
| **HSE Dublin Midlands** |  |
| **HSE South** |  |
| **HSE West** |  |
| **HSE North West** |  |

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| **Please give any further information that may be relevant to your application** |

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| **If you have any learning difficulty, disability (physical or other) or medical condition that might necessitate special requirements or facilities, please give brief detail (Information provided will be private and confidential)** |

**Note: If extra space is required, please use a separate A4 sheet with title for each section being completed**

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| **EDUCATION & TRAINING HISTORY**  **Please include All Nursing/Midwifery Registration Courses and all Other Relevant Training/ Education** | | | |
| **Name & Address of Nursing/ Midwifery School, College, Centre of Further / Higher Education** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Qualification Achieved** | |  | |

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| **Name & Address of Nursing/ Midwifery School, College, Centre of Further / Higher Education** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Qualification Achieved** | |  | |

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| **Name & Address of Nursing/ Midwifery School, College, Centre of Further / Higher Education** | |  | | |
| MM / YYYY | **To** | | MM / YYYY |
| **Qualification Achieved** | |  | | |

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| **Name & Address of Nursing/ Midwifery School, College, Centre of Further / Higher Education** | |  | | |
| MM / YYYY | **To** | | MM / YYYY |
| **Qualification Achieved** | |  | | |

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| **EMPLOYMENT HISTORY** | | | |
| **Please start with most recent employer** | | | |
| **Name & Address of Employer** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Position Held** | |  | |
| **Reason for Leaving** | |  | |

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| **Name & Address of Employer** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Position Held** | |  | |
| **Reason for Leaving** | |  | |

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| --- | --- | --- | --- |
| **Name & Address of Employer** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Position Held** | |  | |
| **Reason for Leaving** | |  | |

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| **Name & Address of Employer** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |
| **Position Held** | |  | |
| **Reason for Leaving** | |  | |

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| **Name & Address of Employer** | |  | |
| **From** | MM / YYYY | **To** | MM / YYYY |

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| **References**  **One reference should be from current or most recent employer.** | |
| **Name:** | **Name:** |
| **Address:** | **Address:** |
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| **Contact details:** | **Contact details:** |
| **Title:** | **Title:** |

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| **How did you hear about this programme?** |

* Newspaper
* Word of mouth
* Social media, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Search engine
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE NOTE: If you have worked in a country/ countries outside of Ireland for a period of 6 months or more, you will need to provide evidence of police clearance from each country. You will not be eligible to undertake the RTN/MP programme without this clearance. Please start this process now to ensure that you fulfil programme entry criteria.**

**PLEASE NOTE: If you require a Visa please ensure the date of the Visa will cover the duration of the programme.**

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| **DECLARATION** | |
| **I agree to the NMPDU Dublin North/ Regional Centres for Nurse and Midwifery Education/ Office of Nursing and Midwifery Services Directorate using my data to communicate with me regarding educational opportunities, the work of the ONMSD, and for evaluation purposes.**  **I confirm that the above information is true and correct, and understand that any misrepresentation will invalidate my application.**  **If accepted onto the programme I agree to:**   * **Provide a photocopy of my NMBI registration or letter directing me to undertake a Return to Practice programme as a prerequisite to registration;** * **Complete Garda Vetting procedures and complete a Garda Clearance form;** * **Complete a Pre-Placement Health Declaration Form and provide information in respect of my immunisation status from my GP.** | |
| **Signature:** | **Date:** |

**Please return completed signed application form to** [**returntopractice@hse.ie**](mailto:returntopractice@hse.ie) **or Nursing Midwifery Planning & Development Unit, HSE Dublin North, Swords Business Campus, Balheary Road, Swords, Co Dublin, K67 X3Y9**

**Please note that incomplete forms will not be accepted**

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| **FOR CNME OFFICE USE ONLY** | |
| Application Number |  |
| Date Received |  |
| Years out of Practice >5 years |  |
| Conditions of Offer |  |
| **Signed:** | **Date:** |
| NMBI Registration confirmed by Certificate  produced by the applicant |  |
| **Signed:** | **Date:** |
| * **NMBI Active Registration** * **Proof of Applicant ID** * **Garda Vetting Completed** * **Covid-19 Declaration** * **Health Declaration** | |