

Please read applicant instructions before completing this form

Please note if all mandatory fields highlighted with a **red border** are not completed the form cannot be submitted by the Director of Nursing/ Director of Midwifery/Head of Service to Nursing & Midwifery Planning & Development Unit for review.

Please do not copy and paste onto this form

Application for funding for Post Registration Education under the Sponsorship of Nursing/Midwifery Third Level Nursing Initiatives (HSE Circular 020/2014) for the Academic Year 2023/2024

1.1 Surname	<input type="text"/>	1.2 First Name	<input type="text"/>
1.3 Employee Number / Personnel Number	<input type="text"/>	1.4 NMBI No.	<input type="text"/>
1.5 Email Address	<input type="text"/>		
1.6 Alternative Email Address	<input type="text"/>		
1.7 Contact Telephone Number	<input type="text"/>		
1.8 I agree that my data may be used;			
1. to communicate with me regarding my role and/or further educational opportunities		Yes	No
2. in relation to the work of the Office of the Nursing & Midwifery Services Director and/or Nursing Midwifery Planning & Development Unit and/or Centre for Nursing & Midwifery Education		Yes	No

1.9 Work Location/Department	1.10 Address for Correspondence
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Eircode	Eircode
<input type="text"/>	<input type="text"/>

1.11 Current Job Title	<input type="text"/>		
1.12 Service Area	<input type="text"/>	1.13 Length of time in current role	<input type="text"/>
1.14 Do you require a Work Visa /Permit to work in the state?		<input type="text"/>	

Note: If answer is "Yes" above please enter Stamp number

1.15 Have you received funding within the past 36 months to <u>commence</u> a Programme/Course	Yes	No
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If you answered Yes to 1.15 please provide the following information

1.16 Name of Programme/Course	<input type="text"/>		
1.17 Date of commencement of programme	<input type="text"/>		
1.18 Qualification Obtained	<input type="text"/>		
1.19 HEI where programme was completed	<input type="text"/>	1.20 Who funded programme?	<input type="text"/>

1.21 Please list previous qualification obtained (please start with most recent)

Programme Title	Qualification	Conferring Body	Date Obtained dd/mm/yyyy	Were you sponsored by HSE to undertake this study

SECTION 2 Details of proposed programme of study

2.1 Programme Title
(as per HEI/3rd level Institution)

2.2 Conferring Institution

2.3 Clinical

Non Clinical

2.4 NMBI approved Programme

Yes

No

2.5 Qualification obtainable

2.6 NFQ Level

2.7 Which year of the Programme/Course are you seeking funding for - please select from drop down

2.8 Programme/Course Code

2.9 Student Number
(if available)

Note: please enter dates in mm/yyyy format e.g. 09/2022

Note: please enter end date in mm/yyyy format e.g. 05/2023

2.10 Programme start date

2.11 Programme end date

2.12 Total Programme fees

Note: Please include total cost of programme fees e.g. Year 1 and Year 2

2.13 Fees for proposed year

Note: please include fees for current year you're applying for only

2.14 What are the main objectives of the Programme

2.15 List programme modules

2.16 If this application is for a Masters degree related to ANP/AMP, has the applicant been recruited/appointed as a Candidate ANP/AMP

Yes

No

If yes, what was date of appointment

2.17 Please outline the specialist area of practice

Section 3 Learning Context

3.1 Please outline how the course that you are applying for integrates with a) your current role and objectives and b) service needs within your area of work

3.1a Current role objectives

3.1b Service needs within your area of work

3.2 How is it envisaged that learning from this programme will be applied to the *workplace in general*?

3.3 Suggest how learning from this programme may be applied to a *specific* service development/improvement initiative

3.4 What future role is it envisaged that the applicant will take in the organisation after completing this programme?
Has this programme been identified to support your PDP ?

3.5 Consider project work to be undertaken as part of this programme (including dissertation) How are these to be linked with the organisation/service area? Where possible state proposed project titles and plans

3.6 I have met with my line manager to discuss my learning contract, the details of which are approved by Director of Nursing/Director of Midwifery / Head of Service

Yes

No

Section Four- Applicants Declaration of Understanding—Please Read Carefully

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

A fully completed Application Form & Learning Contract for Post Registration Education under the Sponsorship of Nursing/Midwifery Third Level Nursing Initiatives (HSE Circular 020/2014) must be submitted to and approved by the NMPDU prior to commencing any formal academic studies

If my programme of study extends beyond one academic/calendar year, it will be necessary for me to submit a fully completed Application Form & Learning Contract for Post Registration Education under the Sponsorship of Nursing/Midwifery Third Level Nursing Initiatives (HSE Circular 020/2014) to the NMPDU for funding for the second and any subsequent year

If I transfer to a different Programme, I will be required to submit a new application for funding as this application will no longer be valid

If I change employment (within the HSE/HSE funded service) during the application process or prior to commencement of the Programme, I will be required to resubmit Section 4 of this application completed by myself, the Line Manager and the Director of Nursing/Director of Midwifery or Head of Service from my new place of employment

On completion of the academic year, I will be required to provide evidence of successful completion of the Programme of study to the Director of Nursing/Director of Midwifery/Head of Service

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.'

As per HSE HR Circular 020/2014 the following criteria applies in the event where repayment of fees or salary is required: 'Where an employee is required to repeat elements of a Programme they must remain in the employ of their current agency during the repeat period. If they cease employment or do not complete the programme they will have their sponsorship terminated and will be required to repay fees. Such repayments shall be made to the public health service agency where they were employed. In exceptional circumstances all the above repayments may be waived or deferred at the discretion of the employing Health Service Agency.

I will notify the Director of Nursing/Director of Midwifery/Head of Service and the NMPDU in writing should I:

- Fail to obtain a place on the programme
- Not accept my place on the programme
- Defer my place on the programme
- Discontinue the programme
- Change length of programme, i.e., from full time to part time

As per HSE HR Circular 020/2014 I understand that no funds will be provided for repeat of modules, units of study, deferrals or examination fees. Such fees will be borne by me.

I agree to submit my completed dissertation or thesis, if applicable, onto LENUS accessible at <http://www.lenus.ie/hse/>

I agree to the NMPDU communicating with the relevant HEI as required for the processing of my Programme fee

I understand that the personal details I have provided for this Programme will be held and processed by the NMPDU in accordance with GDPR and Data Protection Regulations

By ticking this box I understand that I am declaring that I have read, understand and accept the terms and conditions outlined in this form and in HSE Circular 020/2014 and I hereby apply for funding as outlined above in line with these conditions.

Name _____ Date _____ **Note: please enter in dd/mm/yyyy format**

Note: Please type full name only (digital signature not possible)

This is an important document, please ensure that you retain a copy for your records

You should now save this form and forward as email attachment to your Line Manager

Line Manager's Declaration of Understanding

Please tick this box to confirm you have had a discussion with the Applicant regarding this application

4.2 I confirm that;

the applicant has a satisfactory service record

the terms of the applicant's contract of employment allows him/her to fulfil the service commitment associated with sponsorship

the applicant is currently registered with the NMBI

the proposed course of study is relevant to the applicant's area of practice **and/or**

the proposed course of study is aligned to patient and / service needs

By ticking this box I understand that I am confirming that the applicant meets the conditions above and I am recommending that the application for funding be endorsed by Director of Nursing/Director of Midwifery/Head of Service.

Note to Line Manager: Please ensure applicant has completed all mandatory fields above prior to emailing this form to the DON/DOM/ Head of Service as incomplete forms cannot be submitted for review. Please enter your name, date and contact details below

4.3 First-Name

4.4 Surname

4.5 Email

4.6 Tel No

4.7 Date

4.8 NMBI No

Note: please enter date in dd/mm/yyyy format

On completion Line Manager should save form and forward as attachment to Director of Nursing/Director of Midwifery/Head of Service

5. Director of Nursing/Director of Midwifery/Head of Service Approval and sign-off

Note to DON/DOM/Head of Service: Please enter name, date and email address below Click on the SUBMIT button When prompted please Click Continue (this will generate an email with the form attached) Click send on email to forward the form to NMPDU for review. You will receive an acknowledgment email once received.

5.1 First-name

5.2 Surname

5.3 Email address

5.4 Tel No

5.5 Date

5.6 NMBI No

Note: please enter date in dd/mm/yyyy format

Comment (Optional): for completion by the Line Manager, Director of Nursing/Director of Midwifery/Head of Service

Note to DON/DOM/Head of Service: If all mandatory fields above are fully completed and the form fails to submit please save this form and attach to an email and forward to nmpdu.dne@hse.ie

Should you have any queries regarding completion of this form please email: nmpdu.dne@hse.ie or telephone 041 6850677 / 6860733 Thank you!

For Office use only