Certificate in Nurse Authority to Prescribe Ionising Radiation (X-Ray)

Programme Application Form (2019)

Full Name:
Professional Qualifications:
Academic Qualifications:
Employee Number: **NMBI PIN:**
Hospital/Healthcare Institution: **Area of Practice:** _____ **Position:** _____ **Number of Years in Current Position:** _____ **Work Telephone Number:** _____**Work Email address:**_____
Please tick as relevant: **Full Time** □ **Job Sharing** □ **Reduced Hours** □ If reduced hours please specify hours per week _____
Please tick as relevant: **Day duty only** □ **Rotating day and night duty** □
Name of Director of Nursing: **Phone Number:** **Email Address:**
Name of Nominated Person with responsibility for overseeing Nurse Referral for Ionising Radiation (X-Ray) in the designated clinical area/s **(Must be at least ADON / Practice Development Coordinator grade)** **Name:**_____ **Grade:**_____ **Phone Number:** **Email Address:** **N.B. This section must be completed by the Director of Nursing**

N.B. Please Return Completed Application Form, CV and Declaration Form to: Ms. Elizabeth Reilly, Regional Centre of Nursing & Midwifery Education, Connolly Hospital, Blanchardstown, Dublin 15, by closing date of: August 9th 2019.

Name of Clinical Supervisor: (Medical Consultant as entered on Declaration Form) _____ **Position Held:** _____ **Phone Number:** _____ **Email Address:**_____
Applicant's Home Address: **Home Telephone Number:** **Mobile Number:** **Email Address:**

Venue for programme attendance: **RCNME Connolly Hospital Blanchardstown**
Preferred address for official mail: **Home** □ **Work** □

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Applicant Curriculum Vitae

Name:
Current Position: **Number of Years in Current Position:**
Work Address:
Designated Clinical Setting:

Professional Qualifications:

Title	Awarding Body	Year

Academic Qualifications:

Title	Awarding Body	Year

Post Registration Nursing Employment History (please record in reverse chronological order)

Hospital/Healthcare Institution	**From - To**	**Duration** (years, months)	**Position Held**	**Area of Practice**

Signature: _____ **Date: _____**

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