Post Graduate Certificate in Oncology nursing

Declaration Form to be completed on behalf of the Health Service Provider by the Director of Nursing/Midwifery/Equivalent Authorised Manager and submitted with the application.

Programme Title: ____

Name of Applicant (as on NMBI register): ____

Name of Health Care Institution: ____

Applicant Practice Area: ____

To be completed by the Director of Nursing/Midwifery/Equivalent Authorised Manager.

I wish to confirm the following:

1) The applicant will be working clinical practice for the duration of the programme for a minimum of 19.5 hours a week

2) The applicant will be released from practice to attend the programme requirements

3) There is/will be a Clinical Preceptor and/or Clinical Facilitator to support learning in the specialist area of practice for the duration of the programme

4) The applicant has a minimum of six months of post-registration experience (excluding courses)

Signed by the Director of Nursing/Midwifery/Equivalent Authorised Manager:

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Printed name of the Director of Nursing/Midwifery/Equivalent Authorised Manager:

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Date: ________________________