



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 in the relevant specialist area 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) and at least six months experience in the speciality pathway applied for.

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

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

Date: _____