UCD School of Nursing, Midwifery and Health Systems

DECLARATION FORM

To be signed by the Director of Nursing

Date:______________________

Module Title: **National Foundation Education Module in Critical Care Nursing**

Student's name: ____

(as on Nursing and Midwifery Board of Ireland Register)

Student's NMBI number: ____

In what capacity do you work? Job Share_______ Part time______ Full time_________

If Part Time/Job Sharing, how many hours per month do you work?_________________

Are you engaged in day and/or night duty? Day_____________ Night_________________

Students must be engaged in relevant clinical practice for a minimum of 78 hours per month for the duration of the programme for which they have applied.

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

- 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.'
- I shall be liable to repay the programme fees to the HSE (employing public health service agency) if:
  - I do not complete my programme
  - After the completion of my programme I cease working in my employing public health service agency and have not worked for a minimum period of 12 months or for the length of the academic course undertaken, whichever is longer or
- I understand that no funds will be provided for repeat modules, units of study, deferrals. Such fees will be borne by me.
- I understand that my personal data will be processed between the HSE and Third Party (Higher Education Institute) for the purpose of performance monitoring against contract and compliance with HSE HR Circular 020/2014.

I agree with all of the above.

Signature of Applicant _________________________________ Date: _________________________

Line Manager Declaration (or delegated authority authorised by DON/M)

I have held a discussion with _______________________________________ regarding this application.

I (a) am satisfied that the applicant fulfils the service requirement for this sponsorship as per HSE HR Circular 020/2014 & funding approved by the ONMSD and (b) agree to monitor and action any non-compliance as per HSE HR Circular 020/2014.

Name *(in block capitals)*: ______________________________________ Grade: __________________

Signature: ____ Date: ____________________

I (Director of Nursing/Midwifery) verify that the above named student is currently engaged in nursing/midwifery practice relevant to the programme and will be supported by the hospital to receive the necessary clinical experience required to successfully complete the programme.

PRINT ____

Director of Nursing/Midwifery

Signature:____

Student's Employment Address: ____

Area of Clinical Practice:____