**Post Registration Clinical Experience Form**

**Advanced Practice (Nursing/Midwifery) MSc, GD, GC**

**Applicant’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NURSING EXPERIENCE SINCE REGISTRATION

(Starting with most **recent experience**; may be continued on separate sheet). All columns must be completed.

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| --- | --- | --- | --- | --- |
| **NAME AND ADDRESS OF EMPLOYER** | **POSITIONS**  **HELD**  (include grade and current position) | **TYPE OF EXPERIENCE (**e.g. acute, medical, elderly, paediatrics, midwifery, community, etc.) | **From – To**  (month & year/s)  If not full-time specify otherwise | **No. of**  **Months/ Years Employed** |
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1. Please identify the clinical area in which you wish to get qualified

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1. Nursing and Midwifery Board of Ireland (NMBI) divisions of register and PIN

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3. Please identify your medical mentor

1. Name, address and contact number of a nurse manager for professional reference:

(Must be from current employment setting). Reference may be sought.

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1. Name of prescribing site co-ordinator and contact details.

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**I acknowledge that the particulars given on this form are in all respects true.**

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_