THE PRIMARY EAR CARE CENTRE

APPLICATION FORM TO ATTEND THE NATIONAL DIPLOMA IN PRIMARY EAR CARE

Which date do you wish to attend?:- _____

How did you learn about this course? Internet/Publications/Colleagues/Attended an Ear Care Study Day/Other *(Please circle appropriate answer)*

Title:- MRS/MISS/MS/MR Please use capitals and black ink when completing this form

Surname:- _____ First Name(s):- _____

Qualifications: _____

Work Address *(including name of GP if applicable)*:-

_____

_____

_____

Post Code:- _____ Work's Tel No:- _____

E-mail Address:- _____ Job Title:- _____

Home Address: _____

_____

_____

Post Code:- _____ Home Tel No:- _____

We may use your details to send information and updates about future events such as our bi-annual Conference. It may also be used to respond to your enquiries, questions, and/or other requests. Please tick the box if you happy for us to do so ☐

Where, and for whose attention, should the invoice to cover your course fees be sent?

_____

_____

_____

/Cont Overleaf ….

If your organisation requires a purchase order before payment can be made, please attach it to this form and quote the number here:

Payment by BACS (credit transfer) is the preferred method. The remittance should quote our invoice number and be sent to: The Rotherham NHS Foundation Trust, Financial Services, c/o Woodside, 120 Moorgate Road, Rotherham, S60 2TY

Previous ear care experience:
(eg. use of auriscope / irrigator)

Recent courses attended & qualifications gained:

Reasons for wishing to complete this course:

Have you any dietary/special needs? YES/NO

If 'Yes', please state:

Please supply the name and address of a colleague at your place of work who will mentor you to complete the course and programme of clinical competence:

_____

_____

_____

_____

Please return this completed application form, **together with a passport-sized photograph** to:

Primary Ear Care & Audiology Services
Rotherham Community Health Centre
Greasbrough Road
ROTHERHAM S60 1RY
(Tel No: 01709 423207/Fax: 01709 423408)
Email: rgh-tr.earcarecentre@nhs.net

PLEASE NOTE: THE FULL FEE WILL BE CHARGED IF NOTIFICATION OF CANCELLATION, IN WRITING OR BY E-MAIL, IS NOT RECEIVED AT LEAST 4 WEEKS PRIOR TO THE COURSE DATE

Diploma Course Mentoring Agreement

As part of the Course you are required to achieve a programme of Clinical Competencies.

This involves having a mentor to supervise your work and to sign to say that they have done so. Please make sure that you have a mentor in place before starting the Course. You and your mentor must sign this agreement.

This is your mentor's agreement to support you in fulfilling the clinical competencies required to achieve the Diploma.

Please ensure that you and your mentor have completed and signed this agreement

Date of Course:- _____

Student's Name:- _____

Job Title:- _____

Work Address:- _____

Email Address:- _____

Contact telephone(s):- _____

Mentor's Name:- _____

Job Title:- _____

Work Address:- _____

Email Address:- _____

Contact telephone(s):- _____

Student's Signature:- _____

Mentor's Signature:- _____

Please ensure that when you and your mentor have completed and signed this form you return it to Ear Care & Audiology Services with your application form