**ADVANCED PRACTICE (Nursing/Midwifery)**

**Site Declaration Form**

Essential Criteria for Site Selection

Site Declaration Form to be completed on behalf of the Health Service Provider by the Director of Nursing/Midwifery and submitted with the college application to the third level institution.

Site Declaration Form

Essential Criteria for Site Selection

Site Declaration Form to be completed on behalf of the Health Service Provider by the Director of Nursing/Midwifery and submitted with the college application to the third level institution.

**Name of Nurse/Midwife Applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Staff Nurse/Midwife / CNM/CMM / CNS/CMS etc.)

Name of Health Care Institution\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department/Unit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NMBI PIN Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Division of the NMBI Register\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Director of Nursing/Midwifery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Clinical Supervisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Clinical Supervisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Yes** | **No** | **Comment/Evidence** |
| **Practice and Education Development** |  |  |  |
| Do you have in place appropriate mentoring arrangements with a named medical mentor? (Please identify name). |  |  |  |
| Do you agree to the ANP/AMP candidate spending clinical hours (no more than 500 hours) in a relevant placement external to his/her work area? |  |  |  |
| Do you have in place a commitment to continuing education for staff supporting advanced nurse/midwife practitioner practice? |  |  |  |
| Will you have in place a sponsorship agreement at local (service) level setting out the arrangements for study leave and financial support for the ANP/AMP candidate? |  |  |  |
| **Health Service Provider** |  |  |  |
| Do you have in place a named individual (e.g. line manager) delegated by the Director of Nursing/Midwifery/Other relevant manager to have responsibility for the ANP/AMP initiative locally and for liaison with the educational provider? (Please supply name). |  |  |  |
| Do you have in place a firm commitment by the hospital/organisation board or Chief Executive Officer or Medical Director/Chairman of Medical Board to support the ANP/AMP initiative? |  |  |  |

|  |  |
| --- | --- |
| **Printed name** of the Director of Nursing/Midwifery/Public Health Nursing/or other relevant Manager(s): | **Printed name** of the Medical Practitioner/Mentor |
| Name of health service provider: | Name of health service provider: |
| Telephone number: | Telephone number: |
| Email: | Email: |

**Signed by** the Director of Nursing/Midwifery/Public Health Nursing/or relevant manager(s):

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed by** the Medical Practitioner/Mentor:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the following:**

1. The form is fully completed. Incomplete forms will not be considered   
 

2. Your mentor is aware of the mentorship requirements for the ANP/AMP programme. The mentor can contact the programme co-ordinator at (see below) for further information prior to signing the form



3. The name you give on the application form is the name by which you are registered with The Nursing and Midwifery Board of Ireland and which will appear on your student ID card, college records and parchment.



**Appendix 1**

|  |
| --- |
| **Declaration /Undertaking in Respect of Third level Academic fees**  *Please retain copy in candidate’s file* |
| Applicant’s Declaration/Undertaking in respect of Third level Academic fees for Nurse and Midwife Medicinal Product Prescribing Programme |
| I understand that proposed leave entitlements will be subject to staffing demands at the time. I further agree that the entirety of the course fees paid by the HSE on my behalf will immediately become due and owing by me to the HSE if I:   * 1. Do not complete the Course successfully within the time frame designated by the relevant Higher Education Institution   2. Cease employment with the Health Service Executive before I have successfully completed the Course   3. Cease employment with the Health Service Executive at any time following successful completion of the programme within the period of twelve months or for the length of the academic course undertaken**.**  I agree to repay the amount of fees paid for me in respect of this course and salary on a pro rata basis for full time programmes. Signed: Date: |
| Director of Nursing/Midwifery/ Public Health Nursing Approval and Sign-Off |
| Signed: Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Director of Nursing/Midwifery/Public Health Nursing Comments (optional) |