|  |  |
| --- | --- |
|  |  |
| **CeNREE FELLOWSHIP PROGRAM APPLICATION FORM** | |

*Please tick on the appropriate profession program that you are applying for along with the information requested below.*

*Please submit the completed application form by 21st* ***of February 2025****. and forward to cenree@uhnm.nhs.uk Thank you and best of luck.*

|  |
| --- |
| **⃝ CeNREE Fellowship** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TELL US ABOUT YOU:** | | | | | |
| **Title:** *(Mr/Ms/Mrs/Dr)* |  | **First Names:** |  | **Preferred Name:** |  |
| **Last Name:** | |  | | **Email Address:** |  |
| **Mobile Number:** *(optional)* | |  | | **UHNM Work Extension:** |  |
| **Category:** | | ⃝ Nurse  ⃝ Midwifery  ⃝ Allied Health Practitioner,  *please specify*:  ⃝ Healthcare Scientist  ⃝ Information officer  ⃝ Pharmacist  ⃝ Pharmacy Technician | | **Registration:** | ⃝ NMC  ⃝ HCPC  ⃝ Others, *please specify*: |
|  |
| **Educational Background:** | | ⃝ Master’s Degree  ⃝ Bachelor’s Degree  ⃝ Diploma  ⃝ Certifications  ⃝ Others, *please specify*: | | | |
| **Applicant’s Signature** | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR APPLICANT’S DEPARTMENT USE ONLY:** | | | |
| **Name of Department:** | |  | |
| **Name of Line Manager:** | |  |  |
| **Line Manager’s Email:** | |  | |
| **Line Manager’s Contact No.:** | |  | |
| **Line Manager’s Approval:** | | ⃝ Yes, I am allowing my staff to join the fellowship training program and agree to support 2.5 CPD days for project work over the course of the programme and one CPD day per month for teaching | |
| ⃝ No, sorry I am not able to allow my staff to join. | |
| **Line Manager’s Signature:** | |  | |
| **FOR CeNREE OFFICAL USE ONLY:** | | | |
| **Remarks:** | **Total Score:** | | |
| **Date:** |  | | |
| **Name:** |  | | |
| **Signature:** |  | | |