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| **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.*

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| **⃝ CeNREE Fellowship** | **⃝ Chief Nurse Fellowship** | **⃝ Director of Midwives Fellowship** |

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| **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** | |  | | | |

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| **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 two CPD days per month (one for teaching and one for project) | |
| ⃝ 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:** |  | | |