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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 on or before 15****th of March 2024****. 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 Name:**  |  | **Middle Name:** |  |
| **Last Name:**  |  | **Email Address:** |  |
| **Mobile Number:** *(optional)* |  | **UHNM Work Extension:** |  |
| **Category:**  | ⃝ Nurse⃝ Midwifery⃝ Allied Health Practitioner, *please specify*:⃝ Healthcare Scientist⃝ Information officer⃝ Pharmacist⃝ Pharmacy Technician | **Registration:** | ⃝ NMC⃝ HCPC⃝ Others, *please specify*: |
|  |
| **Educational Background:**  | ⃝ Master’s Degree⃝ Bachelor’s Degree⃝ Diploma ⃝ Certifications⃝ 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.  |
| ⃝ 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:** |  |