**NEURO-REHABILITATION HCA CARE PROGRAMME**

**APPLICATION FORM**

Please complete all sections:

|  |  |
| --- | --- |
| Name |  |
| Contact telephone or email |  |
| Address |  |
| Have you undertaken education/training in the past three years? If yes, please give course details and state where and year: | |
| Please tell us why you want to undertake this course? Continue on a separate sheet if necessary | |
| In what way do you expect the programme will impact on your practice? | |
| What do you think will be the most challenging aspect of undertaking the course | |
| What do you expect to be the most rewarding aspect of undertaking the course | |
| Is there any specific circumstance that would affect your ability to complete the course? | |
| I declare this information to be accurate and that I will commit to attending each of the study days  Signature  NAME in CAPITALS Date | |

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| --- |
| To be completed by the CLINICAL MANAGER  I confirm I am willing to release (……………………………) to attend the programme that is equivalent to 7.5 hours of a clinical day.  Signature of ward manager and short supporting statement:  FINANCE  CONFIRMATION that the fees of £500 will be paid in advance of the programme starting  Name: Date  Role:  Invoice should be sent to:  Invoice should be sent to:  Attendance will not be permitted until fees have been submitted. |

**Please remember to return this form to Julie Scholes (**[**jscholes@rhn.org.uk**](mailto:jscholes@rhn.org.uk)**)**