**NEURO-REHABILITATION HCA CARE PROGRAMME**

 **APPLICATION FORM**

Please complete all sections:

|  |  |
| --- | --- |
| Name |  |
| Contact telephone or email |  |
| 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 daysSignatureNAME in CAPITALS Date |

|  |
| --- |
| To be completed by the CLINICAL MANAGERI 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 |

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