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| **APPLICATION FORM STAFF MIDWIFE****UL Hospitals Group****Campaign Reference: UHL081120211****Rolling Campaign** |

Completed Application Form should be emailed to uhlrecruitment@hse.ie

|  |  |
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| **Personal Details:** |  |
|  |  |
| **First Name :** |  |
|  |  |
| **Last Name:** |  |
| **Postal address:** |

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| **MOBILE TELEPHONE:(mandatory)** |  |
|  |  |
| **E-mail Address :(mandatory)** |  |

**European Economic Area (EEA)**

Are you an EEA (European Economic Area) National? Yes [ ]  No [ ]

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| **Do you require Authorisation to work in Ireland? Yes** [ ]  **No** [ ] **Do you hold a Stamp 4 Visa? Yes** [ ]  **No** [ ]  (if yes, please provide copy of same with your application)  |
| **If yes, please provide details:** |

**A level of proficiency in the English language is required. Please rate your proficiency in the English language:**

Excellent Good Average Fair Poor

\* **IMPORTANT** Your proficiency in spoken English will be assessed during interview.

**Non EU / EEA Nursing Applicants Only**

Have you completed the International English Language Testing System (IELTS) Academic Test ?

**YES / NO**

If yes, what overall score did you achieve? Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**QUALIFICATIONS & ELIGIBILITY CRITERIA**

1. **Registered in the Midwives Division of the Register of Nurses maintained by Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) or be entitled to be so registered**

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| **Registration** | **Please tick as appropriate to your current status** | **PIN Number** |
| I am a fully qualified Midwife with active NMBI registration in the General division of the Register of Nurses kept by NMBI |  |  |

*Seeking registration with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) is the responsibility of the applicant.*

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| **Education, Qualifications And Training****Give details of your education, qualifications and training to date.** **Please indicate if you did not complete or pass a particular course.** |
| **Schools, colleges and universities attended**  | **From****(Month & Year)**  | **To** **(Month & Year)**  | **Qualification** | **Result**  |
|  |  |  |  |  |
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**Career Overview**

**(use additional pages if necessary)**

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| --- | --- | --- | --- | --- |
| **From (00/00/****0000)**  | **To****(00/00/****0000)** | **Employer**  | **Title of Post**  | **Main Roles and Responsibilities**  |
|  |  |  |  |  |
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**DECLARATION:** It is important that you read this Declaration and then sign.

“I declare to the best of my knowledge that there is nothing in relation to my conduct, character or personal background of any nature that would adversely affect the position of trust in which I would be placed by virtue of this appointment. I hereby confirm my irrevocable consent to the HSE to making such inquiries, as the HSE deem necessary in respect of my suitability for the post in respect of which this application is made. I hereby accept and confirm the entitlement of the Board to reject my application or to terminate my employment (in the event of a contract of employment having being entered into) if I have omitted to furnish the HSE with any information relevant to my application or my continued employment with the HSE or where I have made any false statement or misrepresentation relevant to this application or my continuing employment with the HSE.

Furthermore, I hereby declare that all the particulars furnished on this application form are true, and that I am aware of the qualifications and particulars for the position. I understand that I may be required to submit documentary evidence in support of any particulars given by me on my application form. I understand that any false or misleading information submitted by me will render me liable to automatic disqualification”.

Mis-statements will render an applicant liable to disqualification.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNED (BLOCK CAPITALS) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERENCES**

Please give three referees (including your current employer). Please ensure that the referees you provide are from a clinical perspective. We retain the right to contact all previous employers.

Do you wish us to contact you prior to contacting your referees? Yes [ ]  / No [ ]

**1. Name and Job Title of Referee:**

**Dates From-To (MM/YY- MM/YY):**

**Professional Relationship to Candidate:**

**Postal Address:**

**Telephone Contact Details:** Mobile: Landline:

**Email Address:**

**2. Name and Job Title of Referee:**

**Dates From-To (MM/YY- MM/YY):**

**Professional Relationship to Candidate:**

**Postal Address:**

**Telephone Contact Details:** Mobile: Landline:

**Email Address:**

**3. Name and Job Title of Referee:**

**Dates From-To (MM/YY- MM/YY):**

**Professional Relationship to Candidate:**

**Postal Address:**

**Telephone Contact Details:** Mobile: Landline:

**Email Address:**