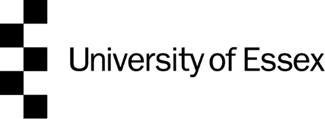
**  
School of Health and Social Care  
Module Application Form**

**HS955 Consultation & Assessment**

All sections of this form to be typed or in capital letters – signatures to be ‘wet’ signatures or ‘electronic’ signatures only – *typed names cannot be accepted as a signature.*

**Module: HS955 Consultation & Assessment** (30 credits)

|  |  |
| --- | --- |
| **Start Date:** |  |

**Please indicate level of study:**

|  |  |
| --- | --- |
| **Level 6 - degree** |  |
| **Level 7 - masters** |  |

**Personal Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title:** | Mr / Mrs / Miss / Ms *(please delete as appropriate)* | | | | |
| **Surname:** |  | | | | |
| **Other Names:** |  | | | | |
| **Former Name** *(if applicable):* |  | | | | |
| **Date of Birth:** |  | **Country of Birth:** | |  | |
| **Nationality** *(as shown on passport):* |  | | | | |
| **Home Address** *(including post code):* |  | | | | |
| **Contact Number:** |  | | **Email Address:** | | *Course information will be sent to this email address.* |

**Clinical Profession** *(please indicate as appropriate)*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nursing:** |  | **Midwife:** |  | | **Allied Health Professional:** |  | **Healthcare Scientist:** |  | **Other:** |  |
| If profession is indicated as ‘**Allied Health Profession’**, please specify role: | | | | | |  | | | | |
| If profession is indicated as ‘**Other**’, please specify role: | | | | | |  | | | | |
| **NMC / HCPC / GPhC Pin:** | | | |  | | | | | | |

**Academic & Professional Qualifications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Award** | **College / University** | **Course Title / Subject** | **Classification / Grade** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Employment History** *(including current role to be listed first – maximum 5 years)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Date From** | **Date To** | **Place of Employment** | **Job Title** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Funding** *(please indicate)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Employer Funded |  | Self-Funded |  | NHS England |  |
| Apprenticeship |  | Fee Waiver |  | Other |  |
| Where funding is indicated as ‘Other’, please specify: | | |  | | |

*Self funded applicants pay the full course fee online prior to registering onto the course. A link will be provided when your place is confirmed, allowing you to pay the course fee prior to registration. Payment can be made by credit card, debit card or bank transfer. Please note the University does not offer payment terms via instalments.*

**Current Employer Details**

|  |  |
| --- | --- |
| Current Employer |  |
| Employer address: |  |
| Post code: |  |

**Employer Funded Invoice Details** *– to be provided by person / team authorising the funding. PO/Ref can be applicants name if employer does not have a purchase order system in place.*

|  |  |
| --- | --- |
| Employer invoice address & post code: |  |
| Invoice email address: |  |
| Purchase order number / reference:  *(if known)* |  |

**Employer Funding Authorisation** *– to be completed by person / team authorising the funding. (electronic signature accepted but not a typed name)*

|  |  |
| --- | --- |
| Name of authorising member of staff: |  |
| Email address: |  |
| Contact number: |  |
| Signature: |  |
| Date signed: |  |

**Employer / Line Manager sign off** *– Please complete & sign. (electronic signature accepted but not a typed name)*

In signing this section you are confirming the applicant has a DBS completed and verified by the employer and is of good health and character. *Please note: We do not require a copy of the DBS for this course.*

|  |  |
| --- | --- |
| Line Manager Name: |  |
| Line Manager signature: |  |
| Date: |  |

**Practice Supervisor Requirements**

You are required to identify a practice supervisor prior to enrolment on the course. The practice supervisor needs to be a registered Medical/Clinical Practitioner and should be at least at SHO or advanced level. Alternatively, an Advanced Care Practitioner may take on this role (ie. nurse, physiotherapist, occupational therapist or paramedic who has completed an advanced practice course and has experience of performing assessment on students).

It is the students’ responsibility to identify a supervisor, and they should be mindful of the opportunities for supervision when selecting this person.

**Practice Supervisor Details** – *To be completed, dated and signed by Practice Supervisor**. Please ensure the contact details are correct as the University will be in contact to verify supervision is in place.*

In completing this section, you have agreed to supervise the applicant while they are taking the consultation & assessment course and you are confirming the applicant has been identified as competent in their field of practice.

|  |  |
| --- | --- |
| Practice Supervisor Name: |  |
| Practice Supervisor Email Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Regulatory body: |  | Professional body pin: |  |
| Signature: |  | Date: |  |

**Processing Personal Data**

The University of Essex will hold and process your personal data for the purposes of maintaining your academic and related records. The information supplied on this form will be processed in line with the Data Protection Act 2018 and the UK General Data Protection Regulations. It will be kept secure and accurate and will only be disclosed in line with the law. Your attendance and Examination Board ratified module marks will be shared with your sponsoring Trust. If you do not wish this to happen, you are responsible for asking your line manager to communicate with the School to this effect. Further information on how the University of Essex processes your personal data is available on the [Privacy Policy for students](https://www.essex.ac.uk/student/my-essex/privacy-notice-students), which can be found on the University’s [Privacy Hub](https://www.essex.ac.uk/disclaimer/privacy-statements). Please note that the information on this application form is required for registration purposes only.

*Please ensure sections requiring a signature, have a wet or electronic signature – typed names cannot be accepted as a signature.*

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant signature: |  | Date: |  |

Applicants employed and funded by the NHS, please send this application form to your NHS Funding Team/Training Team, who will arrange for the funding authorisation section to be completed to confirm the funding is approved and will submit your application on your behalf to [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk). For all other applicants, please sign and date the application and email it to [cpd@essex.ac.uk](mailto:cpd@essex.ac.uk) / Senior Contracts Manager, School of Health & Social Care, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ.