**SCHOOL OF SPORT, REHABILITATION AND EXERCISE SCIENCES**

**Postgraduate Modular Programme Application Form**

| **1 – TITLE OF PROGRAMME** |
| --- |
| Please indicate which programme of course you are applying for by selecting the appropriate box. Please note these are part-time courses.If the programme you wish to apply for does not appear on this page, please contact msk@essex.ac.uk for advice – some programmes offered have separate application forms.For full-time programmes, please make an application online at <https://www.essex.ac.uk/pgapply/enter.aspx> |

| **TITLE OF AWARD (Please select)** | **LEVEL OF AWARD (Please select)** |
| --- | --- |
| Musculoskeletal Ultrasound Imaging [ ]  | MSC/Masters [ ]  |
| Advanced Musculoskeletal Assessment & Practice [ ]  | PG Diploma [ ]  |
| First Contact MSK Practice (PG Certificate only) [ ]  | PG Certificate [ ]  |
| Advanced Musculoskeletal Assessment & Practice (Hand Therapy (PG Certificate only) [ ]  |  |

| **POSTGRADUATE TAUGHT MODULES** |
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| If you are applying for a standalone module, please use the module application form found on the [SRES CPD page](file:///C%3A%5CUsers%5Ckc18431%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CLBBZBV9K%5CContinuing%20Professional%20Development%20courses%20in%20the%20School%20of%20Sport%2C%20Rehabilitation%20and%20Exercise%20Sciences%20%7C%20University%20of%20Essex) under the heading ‘Modules’ |

| **2 - PERSONAL DETAILS**  |  |
| --- | --- |
| Surname/Family name (in BLOCK CAPITALS): |  |
| Other names in full:  | Title |
| Former surname:  | Gender: |
| Nationality (as on passport):  | Country of Origin: |
| Place of Birth: *(if overseas, give Country; if UK, give County)* | Date of Birth: |
| Country of Permanent Residence:  | NMC/HCPC number: |
| Home Address: |  |
|  |  |
|  | Post Code: |
| Email address: | Telephone number: |

| **3 – EMPLOYMENT DETAILS (Professional Category)** |  |
| --- | --- |
| **Clinical Profession** | **Please give job titles** |
| Physiotherapist [ ]  |  |
| Sonographer [ ]  |  |
| Nurse [ ]  |  |
| Other [ ]  |  |
| Work Address: |  |
|  |  |
|  | Post Code: |

**4 - ACADEMIC QUALIFICATIONS**

Give full details, **with supporting evidence such as copies of certificates**, including final classification/grade(s)

| **From** | **To** | **College/University** | **Course Title/Subject** | **Classification or Grade(s)** | **Date Awarded** |
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**5 - EMPLOYMENT HISTORY** (past and current)

| **From** | **To** | **Place of Employment** | **Position held / Duties involved** |
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**6 - LANGUAGES –** If English is not your first language, please give English qualifications and date obtained

| **Provider (i.e. IELTS)** | **Level** | **Date Obtained** |
| --- | --- | --- |
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**7 - FEES CLASSIFICATION**

**Permanent Residence**

UK [ ]  Overseas [ ]  Country:

**If you are already following a course in the UK, please indicate how you have been classified for fees purposes**

Home Student: [ ]  Overseas: [ ]  Other: [ ]  (please specify) Click or tap here to enter text.

**Is the length of your stay in the UK currently limited by immigration control? If yes, give details**

Click or tap here to enter text.

**If you were born in the UK but are working temporarily overseas, please give dates, countries and occupations**

Click or tap here to enter text.

**8 – SOURCE OF FINANCE**

**Proposed Source of Funding**

Health Education (East of England) [ ]

Employer Funded [ ]

Self-Funded [ ]

Other [ ]  (please specify) Click or tap here to enter text.

Has this funding been approved? YES [ ]  NO [ ]

**IF YOU HAVE CONFIRMED FUNDING THROUGH YOUR WORKPLACE, PLEASE COMPLETE THIS SECTION**

| Name and position of authorising member of staff (print name): |  |
| --- | --- |
| Signature of authorising member of staff (written or electronic): | Date: |

**An invoice will be sent to your Employer via email, please provide your employer’s finance section details below.**

| Employer: |  |  |
| --- | --- | --- |
| Contact Name: |  |  |
| Contact Email Address: |  |  |
| Contact Address: |  |  |
|  |  |  |
|  |  |  |
|  |  | Post code: |
| Contact Telephone Number: |  |  |

**If you have any queries relating to funding, please email** **msk@essex.ac.uk**

**9 – DISABLED APPLICANTS AND APPLICANTS WITH INDIVIDUAL REQUIREMENTS**

If you have a disability, medical condition, access requirement or individual need that means you may require extra support or specific facilities for accommodation, please briefly state your requirements:

| **10 – HAVE YOU APPLIED TO STUDY AT THIS UNIVERSITY BEFORE?** |  |
| --- | --- |
| Yes [ ]  Please give details: | No [ ]  |
|  |  |

| **11 – HOW DID YOU FIND OUT ABOUT THE COURSE?** |
| --- |
|  |

| Applicant’s signature (written or electronic): | Date: |
| --- | --- |

| Line Manager’s signature: | Date: |
| --- | --- |
| Print Name: |  |

| **Where to return the form**  |
| --- |
| **Please return your completed form along with any supporting evidence via email to** **msk@essex.ac.uk** **Postal Address:** School of Sport, Rehabilitation and Exercise SciencesUniversity of EssexWivenhoe ParkColchesterEssex CO4 3SQ**Please note: As we are currently working remotely there may be a delay in receiving postal copies** |

| **DATA PROTECTION ACT 1998**The University of Essex has a notification under the Data Protection Act 1998 to enable it to hold and process personal data about its students for the purposes of maintaining their academic and related records. The information supplied on this form will be held under the terms of the Act, it will be kept secure and accurate and will only be disclosed to people who have a need to know in accordance with the Act. *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.****Please note that the information on this application form is required for registering purposes only.*** |
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| **EQUAL OPPORTUNITIES** |
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| This form will be detached – Please complete and return it with your application.The information you provide will be held on database and will only be used for statistical analysis by HESA and certain other bodies that deal with the funding of educationThank you |

| **PERSONAL DETAILS** |  |
| --- | --- |
| Last Name: | Title: |
| First Name(s) (for official purposes) | Preferred first name: |
| Date of Birth: | Gender: |
| Your Nationality |  |

| **Your Ethnicity (please tick)** |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| White British | 11 [ ]  | Asian or Asian British – Indian | 31 [ ]  | Mixed – White and Black African | 42 [ ]  |
| White Irish | 12 [ ]  | Asian or Asian British – Pakistani | 32 [ ]  | Mixed – White and Asian | 43 [ ]  |
| Other White background | 19 [ ]  | Asian or Asian British – Bangladeshi | 33 [ ]  | Other Mixed background | 49 [ ]  |
| Black or Black British – Caribbean | 21 [ ]  | Chinese | 34 [ ]  | Other Ethnic background | 80 [ ]  |
| Black or Black British – Asian | 22 [ ]  | Other Asian Background | 39 [ ]  | Prefer not to say | 98 [ ]  |
| Other Black background | 29 [ ]  | Mixed – White and Black Caribbean | 41 [ ]  |  |  |

| **Disability (please select any which you consider apply to you)** |
| --- |
| In addition to providing information for HESA, completion of this section will assist the University in understanding the needs and requirements of disable staff and also allow us to work towards meeting our obligations under the Disability Equality Act |

| 00 [ ]  | No Disability |
| --- | --- |
| 08 [ ]  | Two or more impairments and/or long-term health conditions |
| 51 [ ]  | A specific learning difficulty such as dyslexia, dyspraxia, or AD(H)D |
| 53 [ ]  | A social/communication impairment such as Asperger’s syndrome/other autistic spectrum disorder |
| 54 [ ]  | A long-term health condition such as cancer, HIV, diabetes, chronic heart disease, epilepsy |
| 55 [ ]  | A mental health condition, such as depression, schizophrenia, or anxiety disorder |
| 56 [ ]  | A physical impairment or mobility issues, such as difficulty using arms or using a wheelchair or crutches |
| 57 [ ]  | Deaf or serious hearing impairment |
| 58 [ ]  | Blind or serious visual impairment uncorrected by glasses |
| 96 [ ]  | A disability, impairment or long-term health condition that is not listed above |
| 97 [ ]  | I do not wish to provide this information |