CENTRE OF NURSE EDUCATION,
MERCY UNIVERSITY HOSPITAL, CORK LIMITED

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Centre of Nurse Education, Mercy Hospital

Please complete all appropriate sections. Incomplete forms may be returned.
Your address, NMBI number, mobile number & email are requested to enable us to manage all matters relating to this application. Signature of this form indicates your consent to use your contact details in relation to this programme. This information will be recorded on a database.

COURSE DETAILS (BLOCK CAPITALS)

COURSE TITLE: **CLINICAL AUDIT PROGRAMME**

DATE: _____ **COURSE FEE INCLUDED (if applicable):**_____

LINE MANAGERS NAME (print) & SIGNATURE: _____

LINE MANAGERS EMAIL ADDRESS: _____

PERSONAL DETAILS (Please Print)

AN BORD ALTRANAIS (NMBI) PIN NO:_____
Mandatory information to secure booking

FULL NAME:_____

JOB TITLE:_____

***MOBILE NUMBER:**_____ **WORK NO:**_____
**This number will be used to make contact with you in relation to this application*

EMAIL ADDRESS:_____
Your email may be used to send on pre-course information.
If you do not wish to be contacted with further dates of various study days, please tick this box □

PLACE OF EMPLOYMENT:_____
FULL ADDRESS:_____
_____

PTO

HOME ADDRESS:_____

SIGNATURE:_____

You will receive a reminder text prior to course commencement.

NB: If you cannot attend, it is the responsibility of the participant to contact us in person at and give at least 48hour notice of cancellation.

If you have paid for a course and do not attend or give at last 48hrs notice of your cancellation, the fee will be non refundable

Your line manager will be contacted if you do not attend the course.