



## Innisfree International College & Convention Centre *An Oasis for Reflective Inspiration*

Lough Gill, Sligo, Republic of Ireland

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### Innisfree International College & Convention Centre (IIC&CC) Prep Course Programme (PCP) requirements for **Physiotherapist (PT)**

**In collaboration with MGH Institute of Health Professions, USA.**

#### **Personal Details:**

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Last name: \_\_\_\_\_

Email address: \_\_\_\_\_

Passport number: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

Country of Residence: \_\_\_\_\_

Passport date of issue: \_\_\_\_\_

Passport date of expiry: \_\_\_\_\_

Male/Female: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Children      Y       N       If yes, number \_\_\_\_\_

6 x coloured  
passport  
sized photos

#### **Permanent Address:**

Home address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

**Qualifications:**

Educational background (please provide details. Attach proofs as appropriate.)

Secondary School Form V or equivalent

Degree and diplomas obtained other than Bachelor of Physical Therapy

Bachelor of Physical Therapy, (NLT three years syllabus, attach full transcript), from an accredited PT program, recognised as such by the government in the country of issuance

Valid/Current National PT Licence/Registration details. State country where issued (Or membership in a recognised international association or agency.)

Medium of instruction/Were English text books used?

Y  N

If yes, to what extent

NPTE or equivalent examination results if available (attach copy of results.)

**Experience:**

Can you provide proof of NLT two years postgraduate experience as a Physiotherapist?

Y  N

If yes, please give details

Can you provide age specific practice experience in any or all of the following age ranges?

0-18

Y  N

19-55

Y  N

56 and over

Y  N

If yes, please give details and attach proofs

**English Language proficiency skills:** (attach most recent test results.)

(Level must have been attained within the previous 18 months.)

TOEFL:

Y  N

If yes, PBT score \_\_\_\_\_ CBT score \_\_\_\_\_ iBT score \_\_\_\_\_

IELTS: – academic module

Y  N

If yes, give overall result \_\_\_\_\_

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**Areas of specialisation:**

Provide a self-reported typewritten summary of supervised clinical experiences to include:

Dates and number of clock hours of each supervised clinical experience

Type of facility in which each supervised clinical experience took place

Overall focus of each supervised clinical experience:

Orthopedics

Y  N

Paediatrics

Y  N

Geriatrics

Y  N

Neurologic

Y  N

Sports/ Medicine

Y  N

Modalities/Manual Skills

Y  N

Prosthetics/Orthotics

Y  N

Computerised Testing

Y  N

**(Type written report attached)**

Y  N

**Are you prepared to undertake**

a CORI check

Y  N

the Finger Print Process

Y  N

the NPTE or equivalent examination

Y  N

the CGFNS Certificate Program

Y  N

the VisaScreen

Y  N

Do you have a genuine desire to work and live abroad

Y  N

**Additional Information**

Make sure that you have attached the following to this application or present originals (where indicated) at time of induction on the PCP:

- a. At induction be prepared to present two (2) forms of valid, original identification, one of which must have your signature: Passport AND another form of government/official issued identification, such as a driving licence or other photographic identification.

Y  N

- |   |                            |                            |
|---|----------------------------|----------------------------|
| b. Six (6) coloured, passport sized photographs.  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| c. A current, detailed resume.  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| d. Authenticated High School Leaving Certificate.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| e. Authenticated Professional Qualification as RGN/PT/OT,<br>as applicable.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| f. A Transcript of professional training which must include theory<br>and clinical hours.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| g. Authenticated ESL examination result(s)  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| h. At induction be prepared to present a copy of a current,<br>valid practicing professional licence as RGN/PT/OT, as applicable.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| i. A certificate of 'Good Standing/Registration or Licence' or a certificate<br>of employment from each country in which you have practiced.  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| j. An official certificate of service covering a minimum period<br>of two (2) years from an authorised person at the health facility<br>where you now work or have worked during the said period. This<br>should be in the form of a letter with reference number<br>and signed by two authorised professionals e.g. Head of Department,<br>Hospital Director or Director of Nursing or equivalent. | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| k. An authenticated copy of ALL pre RGN/OT/PT educational certificates<br>e.g. Secondary School Certificates.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| l. An authenticated copy of ALL relevant licences and registrations.  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| m. An authenticated copy of ALL professional licences acquired in<br>countries other than your home/source country.   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| n. Original Birth Certificate   | Y <input type="checkbox"/> | N <input type="checkbox"/> |

**Declaration**

If your answer is “yes” to any of the following, explain fully in a signed and notarised statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of your application by the IIC&CC or ERC, LLC.

- |   |                            |                            |
|---|----------------------------|----------------------------|
| 1. Has disciplinary action ever been taken regarding any licence,<br>certificate, registration or permits you hold or have held?  | <input type="checkbox"/>   | <input type="checkbox"/>   |
| 2. Have you ever been denied a licence, certificate, registration or permit to<br>practice a professional regulated health occupation in any country?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 3. Have you ever been convicted of, pleaded guilty or nolo contendere to a<br>violation of any Federal law, or local law relating to the use, manufacturing,<br>distribution or dispensing of a controlled substance or drug addiction? | Y <input type="checkbox"/> | N <input type="checkbox"/> |

4. Have you ever been censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? Y  N
5. Have you ever had a malpractice judgment against you or settled any malpractice action? Y  N

I have carefully read the questions in this application form and have answered them completely, without reservation and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information whatsoever or howsoever arising in this application, I hereby agree that such act shall constitute sufficient cause for the denial or suspension or revocation of this application.

I also hereby agree to proceed on this PCP subject to the terms and conditions of same and I confirm that I will at all times abide by the rules, regulations, policies, practices and procedures of the IIC&CC and the ERC, LLC, as amended from time to time.

**N.B. Please refer to [www.iiccc.info](http://www.iiccc.info) for a detailed person specification.**

Signed: \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

Witness:\* \_\_\_\_\_

Date: \_\_\_\_\_

\* Must be a person of professional standing. No relatives please.