

# ENROLMENT FORM



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  
**Registered General Nurse (RGN)**

**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 (attach most recent test results.)

Primary School \_\_\_\_\_

Secondary School Form V or equivalent \_\_\_\_\_

Degree and Nursing diplomas other than Bachelor of Science in Nursing \_\_\_\_\_

Bachelor of Science in Nursing or equivalent of NLT three years study duration from an accredited program. (Attach full transcript) \_\_\_\_\_

Valid/Current National Nursing Registration License \_\_\_\_\_

Registration number: \_\_\_\_\_

NCLEX or equivalent exam results (attach results if available) \_\_\_\_\_

**Experience:** give all necessary details. (attach proofs as appropriate)

Proof of NLT two years of postgraduate experience in an acute care hospital with NLT one year's experience in one or more of the following areas of practice:

• Care of the Adult – Medical Nursing Y  N

• Care of the Adult - Surgical Nursing Y  N

• Maternal Infant Nursing (Obstetrics) Y  N

• Nursing Care of Children (Paediatrics) Y  N

• Psychiatric Mental Health Nursing Y  N

• Community Public Health Nursing Y  N

• Age group experience especially with the following age groups: 50/60, 60/70, 70+ Y  N

• Give details of other nursing experience

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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) \_\_\_\_\_

\_\_\_\_\_

**Specialisation in Older People Care, if any:** (give brief details)

Older people care: \_\_\_\_\_ Y  N

\_\_\_\_\_

Short stay rehabilitation care: \_\_\_\_\_ Y  N

\_\_\_\_\_

Long stay custodial care: \_\_\_\_\_ Y  N

\_\_\_\_\_

Hospice care: \_\_\_\_\_ Y  N

\_\_\_\_\_

Assisted Living: \_\_\_\_\_ Y  N

\_\_\_\_\_

Other: \_\_\_\_\_ Y  N

\_\_\_\_\_

**Are you prepared to undertake**

a CORI check Y  N

the Finger Print Process Y  N

the NCLEX 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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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, as applicable.   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| f. A Transcript of professional training which must include theory 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, 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 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 of two (2) years from an authorised person at the health facility where you now work or have worked during the said period. This should be in the form of a letter with reference number and signed by two authorised professionals e.g. Head of Department, 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 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 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, certificate, registration or permits you hold or have held? Y  N
2. Have you ever been denied a licence, certificate, registration or permit to practice a professional regulated health occupation in any country? Y  N
3. Have you ever been convicted of, pleaded guilty or nolo contendere to a violation of any Federal law, or local law relating to the use, manufacturing, distribution or dispensing of a controlled substance or drug addiction? Y  N
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.