Bord Altranais agus
Cnáimhseachais na hÉireann
Nursing and Midwifery
Board of Ireland

CANDIDATE ELIGIBILITY REPORT

Name:

Date of Birth: **Division Requested:**

Hospital Name

Orientation or Induction Dates (if applicable)

number of weeks from __/__/____ to __/__/____

Adaptation Dates (Supervised Clinical Practice)

number of weeks from __/__/____ to __/__/____

Accumulated Time (Orientation and Adaptation)

number of weeks from __/__/____ to __/__/____

Has the candidate's assessment confirmed that they meet competency requirements for registration?

Yes ☐ No ☐ Date __/__/____

Name of Preceptor or Assessor

Preceptor's Title (staff nurse or midwife etc.)

Ward or Unit

18/20 Ascaill Dhún Charúin, An Charraig Dhubh,
Contae Bhaile Átha Cliath, A94 R299, Éire.

18/20 Carysfort Avenue, Blackrock,
Co. Dublin, A94 R299, Ireland.

T: +353 (0)1 639 8500
www.nmbi.ie

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Signature of Candidate

Date ☐☐/☐☐/☐☐☐☐

Signature of Director of Nursing or Midwifery

Date ☐☐/☐☐/☐☐☐☐

Candidate Declaration

☐ I confirm that I have read and understand this report.

Candidate Recommended for Registration

Yes ☐ No ☐

Hospital Stamp

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