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

INTELLECTUAL DISABILITY (ID) NURSING QUALIFICATION FORM

This form must be completed by the Higher Education Institution (HEI) for the Intellectual Disability Nursing programme undertaken by the applicant. Once completed, it should be returned to the applicant. We may contact the HEI to clarify and validate the information provided.

This form can be used to record an applicant's qualification in **either** an undergraduate or post-graduate course in ID Nursing. The HEI must complete a **separate** form for each programme.

Please note: If the applicant's undergraduate nursing programme is in a division other than ID Nursing, that programme must be recognised first by the NMBI.

Applicant Name:

Date of Birth: (dd/mm/yyyy)

/ /

Qualification Title:

Undergraduate or Post-graduate:
Please select from the drop down menu below

Start Date of Programme:

/ /

End Date of Programme:

/ /

Full-time or Part-time:
Please select from the drop down menu below

Name of HEI/College:

Instructions for Higher Education Institutions

Sections A to C are to be completed by the Head of Nursing Education. Please ensure that all fields of the form are entered or a rationale is provided for incomplete fields.

Incomplete forms will not be processed and will be returned.

A	Please ensure that the transcript of training and the curriculum are sent to the applicant.
B	Complete the summary of education for the programme undertaken.
C	Read and sign the declaration.

Applicant Name:

SECTION A
Transcript and Curriculum

You will also need to provide the **official transcript** and **curriculum** relevant to the applicant's completed programme.

- The transcript **must contain a breakdown of education in clock hours**. Theory and clinical hours must be outlined separately.
- The curriculum must be relevant to the programme completed by the applicant.

☐ Please tick to confirm you have provided the official transcript to the applicant.
(Dated, signed and stamped).

☐ Please tick to confirm that you have provided the official curriculum or programme specification to the applicant.
(Dated, signed and stamped).

SECTION B
Summary of Education

Enter the clinical practice and theory instruction hours for the Intellectual Disability nursing programme completed by the applicant.

Clinical practice hours must refer to hours of **direct patient care** that are mentored, supervised and assessed. **Please note that clinical laboratory hours or simulated learning hours are counted as theory**.

If the transcript for the programme states 'units' or 'credits' of instruction, please enter the number of clock hours in a unit or credit in the table on the right.

☐ Total hours of clinical practice

☐ Total hours of theory instruction

☐ Total of both theory and clinical practice

☐ Number of weeks in a semester

Credits/Units	Equivalent Clock Hours
One clinical credit	
One theory credit	
One lab/simulated learning credit	
One clinical unit	
One theory unit	
One lab/simulated learning unit	

Applicant has Recognised Prior Learning (RPL) / Accredited Prior Experiential Learning (APEL)? ☐

☐ RPL/APEL Hours

Please record the **clock hours** that the applicant **completed** during the clinical practice component (**direct patient care)** of the programme. (Do not include clinical laboratory or simulated learning hours). You may wish to refer to the NMBI *standards and requirements* for registration programmes.

Intellectual Disability Nursing Programme	**Clock hours**
Clinical Practice Components (Direct patient care)	
Health and Social Development of the Child	
Health and Social Development of the Adult (Including Care of the Older Person)	
Specialist Intellectual Disability Nursing (For example: Nurse led services, behaviours that challenge)	
Nursing of Service User Groups in Other Settings (For example: General Nursing, Mental Health Nursing, Care of the Older Person)	
Other (please specify)	

If you are unable to provide the hours for a particular clinical practice component, or you are unable to complete any part of this form, please give the reason below:

SECTION C

Declaration and Contact Details

☐ I certify that the information provided in this form represents a true outline of the theory and clinical practice of the applicant.

Signature:

Print Name:

Title or Position:

Work Email:

HEI/College Official Email:

Date:

/ /

HEI/College Website:

HEI/College Address:

Official Stamp