NHS
Rotherham
Community Health Services

The Primary Ear Care Centre

MICROSUCTION COURSE (2 DAYS)

APPLICATION FORM

Date of Course:- _____

Title:- MRS/MISS/MS/MR

Surname:- _____ First Name(s):- _____

Work Address :- _____

_____

_____

E-mail Address:- _____ Post Code:- _____

Work Tel No:- _____ Job Title:- _____

Home Address: _____

_____

_____ Post Code:- _____

Home Tel No:- _____

Name and address of mentor–

This should be a registered nurse, GP, or audiologist who regularly practises microsuction and can assist you in achieving the programme of clinical competence.

_____

_____

_____

_____

/Cont Overleaf …..

Recent courses you have attended & qualifications gained:

What previous ear care experience have you had?
(eg. use of auriscope; type of irrigator used (if any); experience of hearing aids)

How did you learn about this course? Internet/Publications/Colleagues/Other *(Please circle appropriate answer)*
If 'Other', please state

Have you any dietary/special needs? YES/NO If 'Yes', please state

Where, and for whose attention, should the invoice to cover your course fees be sent?

_____

_____

_____

Payment by BACS (credit transfer) is the preferred method. The remittance should quote our invoice number and be sent to: The Rotherham NHS Foundation Trust, Financial Services, C/o Woodside, 120 Moorgate Road, Rotherham, S60 2TY

Please return the completed form to:- Primary Ear Care & Audiology Services, Rotherham Community Health Centre, Greasbrough Road, Rotherham, S60 1RY (Tel No: 01709 423207/ Fax No: 01709 423408)

PLEASE NOTE: THE FULL FEE WILL BE CHARGED IF NOTIFICATION OF CANCELLATION, IN WRITING OR BY E-MAIL, IS NOT RECEIVED AT LEAST 4 WEEKS PRIOR TO THE COURSE DATE