NHS
Rotherham
Community Health Services

The Primary Ear Care Centre

HCA MICROSUCTION COURSE

MENTOR APPLICATION FORM

Date of course:- _____

Title:- MRS/MISS/MS/MR

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

RCN Member:- YES/NO

Work Address: _____

_____

_____

Post Code:- _____ E-mail address:- _____

Work Tel No:- _____ Job Title:- _____

Qualifications:- _____

Home Address:- _____

_____

_____

Post Code:- _____ Home Tel No:- _____

Name of Healthcare Assistant/Assistant Practitioner who you will mentor:-

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

Cont Overleaf …

Have you previously attended an ear care course? – *please give title, location and date, and trainer's name (if possible)*

_____

_____

_____

Describe the ear care which you provide, how often, whether as part of a normal clinic or special ear care clinic:-

_____

_____

_____

_____

Have you any dietary/special needs? YES/NO

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

_____

_____

_____

If your organisation requires a purchase order before payment can be made, please attach it to this form and quote the number here:

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 this completed application form, **together with a passport-sized photograph** to:

Primary Ear Care & Audiology Services
Rotherham Community Health Centre,
Greasbrough Road
ROTHERHAM S60 1RY
(Tel No: 01709 423207/Fax: 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