APPLICATION FORM
FOR POST BASIC HAEMODIALYSIS NURSING PROGRAMME FOR STAFF NURSES

SECTION A: COURSE APPLICATION CHECKLIST	
Please put a checkmark beside the items you have submitted (certified true copy), and include this form with your supporting documents. We will not process applications which are incomplete. ☐ Identification Card ☐ SPM transcript ☐ Perakuan Pendaftaran LJM ☐ APC (Year: _____) ☐ Diploma/Degree in Nursing ☐ Medical Insurance Policy ☐ Blood Test Result (Hepatitis B, Hepatitis C, HIV) ☐ Letter of verification from Employer on working experience ☐ Medical Check-up Form *Certified medically fit by registered medical practitioner within one (1) month from commencement of the programme	**Photo**

SECTION B : PERSONAL PARTICULARS				
Name (Mr/Mrs/Ms) (As per NRIC)				
NRIC No. (New)			Age	
Home Address				
	Postcode		State	
Tel. No. (H/P)			Tel. No. (O)	
Email			Tel. No. (H)	
Marital Status	Single / Married / Widowed / Divorced		Race	
Sex	Male / Female		Nationality	
Possess Own Transport	Yes / No			
Next of Kin Particulars				
Name (Mr/Mrs/Ms) (As per NRIC)				
NRIC No (New)			Relationship	
Home Address				
Tel. No. (H/P)			Tel. No. (O)	

SECTION C : QUALIFICATIONS

C.1 : Education Background

Institute/University	
Graduation Date	
Qualification	**Diploma / Advance Diploma / Degree / Others _____**
Name of Course	
Field of Study	

C.2 : Languages

English	**Spoken : Good / Fair / Poor** **Written : Good / Fair / Poor** **Listen : Good / Fair / Poor**
Bahasa Melayu	**Spoken : Good / Fair / Poor** **Written : Good / Fair / Poor** **Listen : Good / Fair / Poor**

C.3 : Working Experience

Name of Centre/Hospital	**Start Date (MMYY) – End Date (MMYY)**	**Joined Duration (Years & Months)**

Referee 1 (excluding relatives)		**Referee 2 (excluding relatives)**	
Name		**Name**	
Address		**Address**	
Job Title		**Job Title**	
Tel. No.		**Tel. No.**	
Years Known		**Years Known**	

SECTION D : MEDICAL REQUIREMENTS	
Hepatitis Bs Ag	**Non-reactive / Reactive**
Hepatitis B Ab	**_____ IU/L**
Hepatitis C	**Non-reactive / Reactive**
HIV	**Non-reactive / Reactive**
**Please declare your health issues (including mental health issues) here:* _____	

SECTION E: SPONSORSHIP OF POST BASIC HAEMODIALYSIS NURSING PROGRAMME (Select one)

- ☐ Self-sponsored
- ☐ Sponsored by present employer

ENDORSEMENT BY PRESENT EMPLOYER

_____
_____
_____
_____
_____

Name : _____
Designation : _____
Company : _____
Address : _____
_____
Tel. No. : **(O)** _____ **(Fax)** _____

Company Rubber Stamp

SECTION F: DECLARATION

I/We declare the information given in this application is true and complete. I/We understand any misleading information or willful omission is sufficient reason for rejection of admission to the course.

I/We hereby declare that I/we have read and understood the contents of the privacy notice of NKF displayed on the NKF website at www.nkf.org.my and confirm my/our consent for NKF to use my/our personal data for the purposes and to the parties stated in the privacy notice.

_____
Signature of Employer
Date : _____

_____
Signature of Applicant
Date : _____

For Office Use Only:	
Date Received (Stamp):	Receiving Officer: