

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.

- | | |
|---|--|
| <input type="checkbox"/> Identification Card
<input type="checkbox"/> SPM transcript
<input type="checkbox"/> Perakuan Pendaftaran LJM
<input type="checkbox"/> APC (Year: _____)
<input type="checkbox"/> Diploma/Degree in Nursing
<input type="checkbox"/> Medical Insurance Policy | <input type="checkbox"/> Blood Test Result (Hepatitis B, Hepatitis C, HIV)
<input type="checkbox"/> Letter of verification from Employer on working experience
<input type="checkbox"/> 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)**

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: _____	

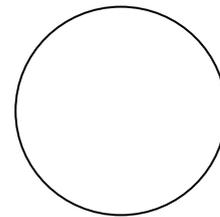
SECTION E: SPONSORSHIP OF POST BASIC HAEMODIALYSIS NURSING PROGRAMME (Select one)

- 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: