Ministry of Health
Republic of Seychelles

ADVANCED DIPLOMA IN MIDWIFERY APPLICATION FORM (Duration 18months)

The programme aims to equip participants with the knowledge, skills and attributes to become competent, analytical and reflective practitioners and to provide safe and comprehensive quality midwifery care to individuals, families and communities within the legal and ethical framework set by the Seychelles Nurses and Midwives Council.

Criteria: Registered Nurse

APPLICATION CHECKLIST

Application Form duly filled	
Copy of Identity Card	
Copy of Birth Certificate	
Copies of end of Secondary School level certificates (eg GCE, IGCSE, O level, National Examination, A level and any other relevant academic certificate	
Copies of end of Secondary School level transcript (eg GCE, IGCSE, O level, National Examination, A level and any other relevant academic transcript	
Registration and license to practice as a nurse	
2 references- one from your immediate supervisor and one from a leader of any health professional	
Professional Portfolio	

ORIGINAL CERTIFICATES SHOULD NOT BE SENT WITH THE APPLICATION FORM

For official Use Only

Reference Number	
Received on/ by	
Interview Date	
Interview Outcome	

PERSONAL INFORMATION			
Your family name and other names should be the same as the official names on your ID card			
First Name(s) *(in BLOCK letters)*			
Family Name (Surname) *(in BLOCK letters)*			
Gender	☐ MALE ☐ FEMALE	**Date of Birth** *(dd/mm/yyyy)*	
Place of Birth			
Country of citizenship			
National Identity Number (N.I.N)			
Indicate whether you suffer from any illness that might affect your ability to participate in the proposed study programme (*e.g. epilepsy, asthma, diabetes, significant visual impairment, motor disability or significant hearing loss, etc.*) **A '***YES***' answer will not affect your chances of studying at NIHSS.**			☐ YES ☐ NO
If you have answered 'YES', provide brief details of the illness and any special requirements or support you may require to complete your programme of study on a separate sheet of paper. Please attach a copy of your doctor's assessment of your needs.			

YOUR CONTACT DETAILS Please provide an address at which the outcome of this application can be communicated to you.	
Full Address; **Sub district** **District** *(in BLOCK letters)*	
Mobile Phone Number And Any other Phone Number	+ +
Email Address	

OTHER CERITIFICATES (if applicable)	
1	Organization/ Institute/ School: _____ Date completed (**Month/ Year**): _____/ _____ Certificated obtained(title of certificate): _____
2	Organization/ Institute/ School: _____ Date completed (**Month/ Year**): _____/ _____ Certificated obtained(title of certificate): _____
3	Organization/ Institute/ School: _____ Date completed (**Month/ Year**): _____/ _____ Certificated obtained(title of certificate): _____

CURRENT STATUS (tick and answer accordingly)	
1	Currently studying: ☐ Where:_____
2	Employed: ☐ Where:_____
3	Self- Employed: ☐
4	Unemployed: ☐
5	(if applicable) Are you currently or have you ever been employed by the Ministry of Health? Yes ☐ No ☐ If yes, in what capacity?_____ Date (Year): _____ to _____

EMPLOYMENT RECORD (If applicable) (Starting with your present or most recent.)	
Current Post	Post: _____ Place of work: _____ Employer: _____ Date started: _____ to _____ Contact details: _____
Previous Post	Post: _____ Place of work: _____ Employer: _____ Date started: _____ to _____ Contact details: _____
Previous Post	Post: _____ Place of work: _____ Employer: _____ Date started: _____ to _____ Contact details: _____

REASON(S) FOR APPLYING (compulsory) Explain briefly why you have applied for the Programme
_____ _____ _____ _____ _____ _____ _____

REFEREES (compulsory) Referees should not be any relatives	
Name: _____ Position: _____ Place of Work: _____ Contact details: _____	Name: _____ Position: _____ Place of Work: _____ Contact details: _____
DECLARATION BY THE APPLICANT (must be completed and signed by the applicant)	
I _____ (full name), certify that the statements made by me to the foregoing questions are true, complete and correct to the best of my knowledge and belief I understand that any false statement made on this form may provide grounds for the withdrawal of any offer or dismissal after the acceptance of the offer to follow the programme. Date : _____ Signature:_____	

For any clarification Contact Us: 4 24 20 06
Registrar @ NIHSS Ms Seth Tel: 4 24 21 21 or email v.seth@health.gov.sc
Or
In-Service Programme Coordinator @ NIHSS Mrs Camille Tel: 4 24 2112 or email: bcamille@health.gov.sc