

Castlemaine Health

**RETURN TO PRACTICE / INITIAL REGISTRATION
FOR OVERSEAS NURSES APPLICATION FORM**

1. CONTACT DETAILS	Name: _____ Address: _____ Phone: _____ Mobile: _____ Email: _____
2. QUALIFICATIONS	Division: <input type="checkbox"/> One <input type="checkbox"/> Midwife <input type="checkbox"/> Two <input type="checkbox"/> Other
Please complete the following details as accurately as possible. It is important to know exactly what your experience and educational needs are so we can ensure we provide a suitable program. You may be required to provide supporting information to verify your details.	
3. If your registration has lapsed, the year your registration lapsed?	
4. Year of initial graduation/registration as a nurse.....	
5. Please complete details regarding the last time you practiced nursing and midwifery: a) Year last practiced nursing b) Last place of nursing work c) Main area of work d) Average shifts per week e) Position / Grade / Pay Point f) Highest position / Grade / Pay Point held	
6. AHPRA assessment attached <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?	
7. Police Check attached <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?	
8. The information provided is true and correct Signature:	
<i>OFFICE USE ONLY</i>	Type of Program required:
Division One	Division Two
<input type="checkbox"/> Return to Practice	<input type="checkbox"/> Return to Practice
<input type="checkbox"/> Initial Overseas Registration	<input type="checkbox"/> Initial Overseas Registration
<input type="checkbox"/> Refresher	<input type="checkbox"/> Refresher
Program offered <input type="checkbox"/> Yes <input type="checkbox"/> No Why not?	
.....	
.....	

Return completed form with attached documentation to: Clinical Nurse Education
Castlemaine Health
PO Box 50
Castlemaine Vic 3450