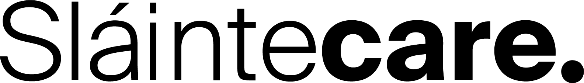
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**Application Form**

**Professional Certificate Referring for Radiological Procedures (Physiotherapists)**

University College Dublin

**Applicants should read the accompanying guidelines provided prior to completing this application form in consultation with their clinical supervisor.**

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| **PHYSIOTHERAPIST APPLICANT DETAILS** | |
| **Applicant Name (as per CORU Registration):** |  |
| **CORU Registration Number:** |  |
| **Grade (e.g. Senior/Clinical Specialist):** |  |
| **Clinical Area:** |  |
| **Work Location:** |  |
| **Contact Details (Email/Telephone):** |  |
| **Proposed programme commencement date[[1]](#footnote-1):** | **September 2024 [ ] December 2024 [ ]** |

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| **GOVERNANCE ARRANGEMENTS** | | |
| ***Please confirm that the following is in place/has been satisfied at your work location.*** | Yes | No |
| All necessary local governance arrangements are in place at the work location to oversee the introduction and implementation of physiotherapist referral for radiological procedures (i.e. Radiation Safety Committee and Local Implementation Group). |  |  |
| An appropriate named clinical supervisor has been identified who will provide support throughout the education and training programme (please refer to the accompanying guidelines provided for further detail). |  |  |
| An agreed schedule for routine audit of physiotherapist referral for radiological procedures is in place or will be implemented prior to commencement of independent practice. |  |  |
| Access to **each** of the following has been confirmed:   * Royal College of Radiologist’s (RCR) *iRefer Guidelines[[2]](#footnote-2)*, the European Society of Radiologist’s (ESR) *iGuide[[3]](#footnote-3)* or equivalent decision support tool. * PPPGs relating to the reporting of ionising radiation incidents and near miss events. * PPPGs relating to the protection of the unborn child during medical exposures to ionising radiation. |  |  |

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| **SITE DECLARATION** | |
| **Radiologist:** | ‘Radiologist’ is the Clinical Director/Consultant in Administrative Charge (or designate) who is the designated radiologist to the Radiation Safety Committee, within the work location. |
| **Name:** |  |
| **MCRN:** |  |
| **Work Location:** |  |
| **Contact Details Email/Telephone:** |  |
| **Date:** | **Signature:** |
| **Clinical Supervisor:** | ‘Clinical Supervisor’ must be a registered medical practitioner at, minimum, Registrar or Consultant level. |
| **Name:** |  |
| **MCRN:** |  |
| **Work Location:** |  |
| **Contact Details Email/Telephone:** |  |
| **Date:** | **Signature:** |
| **Executive Lead/Senior Manager**: | ‘Executive Lead/Senior Manager’ refers to the person with overall responsibility for governance of the physiotherapy service within the work location (e.g. HSCP Lead, Hospital Manager, General Manager, or equivalent). |
| **Name:** |  |
| **Work Location:** |  |
| **Contact Details Email/Telephone:** |  |
| **Date:** | **Signature:** |
| **Physiotherapy Manager**: | ‘Physiotherapy Manager’ is the Physiotherapy Service Manager to whom the applicant reports professionally. |
| **Name:** |  |
| **CORU Number:** |  |
| **Work Location:** |  |
| **Contact Details Email/Telephone:** |  |
| **Date:** | **Signature:** |

**Please detail you reasons for applying for this education and training programme.**

*In your answer, please give reference to how the programme will benefit you in your physiotherapy role* (Max. 500 words).

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| **PHYSIOTHERAPIST APPLICANT DECLARATION** |
| * + I agree to allow personal information recorded above to be shared between the Department of Health, Health Service Executive, and University College Dublin for the purpose of progressing my application and to support my employer at site level into the future. * I understand that proposed leave entitlements associated with completion of the education and training programme will be subject to staffing demands at the time. * I agree that the entirety of the course fees paid on my behalf will immediately become due and owing by me if I: * Do not complete the programme successfully within the time frame designated by the relevant Higher Education Institution * Cease employment with the HSE before I have successfully completed the programme.   + I agree to reporting specific outcomes which will be agreed by the HSE under the delivery of the SIIF project. * On successful completion of the education and training programme I will: * Provide my work location with evidence of same * Inform the HSE National Health and Social Care Professions Office ([CPD.HSCP@HSE.IE](mailto:CPD.HSCP@HSE.IE)) and my Physiotherapy Manager, by email.   + I confirm that the information provided above is correct and accurate, to the best of my knowledge.   **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

1. Enter number 1 and 2 to indicate your preferred commencement dates. [↑](#footnote-ref-1)
2. Royal College of Radiologists. [Home | iRefer](https://www.irefer.org.uk/). [↑](#footnote-ref-2)
3. European Society of Radiologists. [ESR iGuide | Imaging Referral Guidelines published by the European Society of Radiology](https://www.esriguide.org/). [↑](#footnote-ref-3)