Assessment of Qualifications

Address: Pre-Hospital Emergency Care Council, Assessment of Qualifications Section, Abbey Moat House, Abbey Street, Naas, Co Kildare, Ireland.
E: recognitionqualifications@phecc.ie W: www.phecc.ie

Form B **Professional Reference**

To: APPLICANT

Complete Part 1 only and ensure Part 2 is completed and posted directly to PHECC by the referee.

Part 1 Applicant Details

Applicant's name:

Date of birth: D D M M Y Y Y Y

Address;

Job title/ position:

Part 2

This section must be completed by the referee. The applicant named in Part 1 above is applying for registration in Ireland. You should complete this reference only if you are or have been responsible for managing or supervising the applicant's professional practice or professional training. Please complete Part 2 and return directly to the Pre-Hospital Emergency Care Council at the address above. You may also continue on a seperate sheet.

In what capacity is the applicant known to you (eg employee, student or volunteer):

Employed: *Commencement* D D M M Y Y Y Y *Cessation* D D M M Y Y Y Y

Dates when you supervised the applicant: *Commencement* D D M M Y Y Y Y *Cessation* D D M M Y Y Y Y

Hours worked per week:

Describe the typical work settings and give a range of patients and types of conditions treated.

Describe the applicant's authority to practice EMS. For example: under medical practitioner instructions, independently or in accordance with guidelines or operating procedures.

Were there any restrictions on the applicant's practice? (eg Can work under supervision only).

Part 3 Referee Details

I certify that this reference represents a true and comprehensive statement of the practice of the applicant named in Part 1 above.

Referee name:

Job title / position:

Work address:

Email address:

Telephone number:

(please include international dialing codes where applicable)

Please stamp with offical seal

Signature:

Date:

D D M M Y Y Y Y