Text

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| **Recognition of professional qualifications obtained outside the State**  **Application Form**  [**recognitionqualifications@phecc.ie**](mailto:recognitionqualifications@phecc.ie) |

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| **Checklist** |

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| Complete the following checklist indicating ‘yes’ or ‘non-applicable’ where relevant: |

|  |  |
| --- | --- |
| I have enclosed a **completed application form** (sections 1-4) | Choose an item. |
|  | |
| I have securely uploaded a **passport sized photograph** | Choose an item. |
|  | |
| I have completed the **declaration** (section 4) | Choose an item. |
|  | |
| I have enclosed an **original notarised copy of my passport** | Choose an item. |
|  | |
| I have paid the appropriate **application fee** (non-refundable) | Choose an item. |
|  | |
| I have enclosed my **name change documentation** (notarised in English) if applicable | Choose an item. |
|  | |
| I have enclosed my **professional certificate in pre-hospital care** (notarised English copy of certificate) | Choose an item. |
|  | |
| I have enclosed the **letter/certificate or other evidence** issued by the relevant competent authority certifying successful completion of professional training (notarised English copy) if applicable | Choose an item. |
|  | |
| I have enclosed other relevant **additional qualification certificates** (photocopies in English) as applicable | Choose an item. |
|  | |
|  | |
| The following documents must be sent **directly to PHECC** from the relevant authority: | |
| I have requested testimony of my training and education in English – **Form A**  (If Form A is translated into English, it must be certified by a Notary Public) | Choose an item. |
|  | |
| I have requested a document outlining all of the essential information about my course (syllabus or similar)(in English) to supplement the information provided on the Form A | Choose an item. |
|  | |
| I have requested Choose an item. of professional references – **Form B**  (If Form B is translated into English, it must be certified by a Notary Public) | Choose an item. |
|  | |
| *You may wish to make a copy of your full application and retain for your own records* | |

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| **Section 1: Contact details** |

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| --- | --- | --- |
| I am applying for recognition of my professional qualifications.  I am seeking recognition at the level of: | | Choose an item. |
|  | | |
| Please upload a recent passport sized photograph | | Shape  Description automatically generated with low confidence |
|  | | |
| Title: | Choose an item. | |
|  | | |
| Family name: | Click or tap here to enter text. | |
|  | | |
| Given name:  as per birth certificate/marriage certificate/deed poll | Click or tap here to enter text. | |
|  | | |
| Maiden name: (if different from surname above)  \*if you wish to enter your name as per your Marriage Certificate/Deed Poll please enclose a notarised copy) | Click or tap here to enter text. | |
|  | | |
| Gender: | Choose an item. | |
|  | | |
| Date of birth: | Click or tap to enter a date. | |
|  | | |
| Permanent address: | Click or tap here to enter text. | |
|  | | |
| Address for correspondence:  If different from above | Click or tap here to enter text. | |
|  | | |
| Telephone number:  please include international dialing codes where applicable | Click or tap here to enter text. | |
|  | | |
| Email address: | Click or tap here to enter text. | |

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| **Section 2: Qualifications, education & training** |

1. **Recognition of qualifications**

Applicants exercising mutual recognition rights must attach the letter/certificate or other evidence issued by the relevant competent authority in the Member State certifying successful completion of professional training (see guidelines for more information)

|  |  |
| --- | --- |
|  | |
| Name of competent authority or regulatory body (if relevant): | Click or tap here to enter text. |
|  | |
| Address: | Click or tap here to enter text. |
|  | |
| Website: | Click or tap here to enter text. |
|  | |
|  | |
| Email address: | Click or tap here to enter text. |
|  | |
| Your professional title: | Click or tap here to enter text. |
|  | |
| Your registration number: | Click or tap here to enter text. |
|  | |

1. **Details of education institute where you obtained your professional qualification**

This section is for you to outline the professional qualifications for which you are seeking recognition. If two or more courses were completed, insert details under ‘3. Additional professional qualifications’.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| Name of education institute: | | Click or tap here to enter text. | |
|  | | | |
| Address: | | Click or tap here to enter text. | |
|  | | | |
| Website: | | Click or tap here to enter text. | |
|  | | | |
| Name of course: | | Click or tap here to enter text. | |
|  | | | |
| Commencement: | Click or tap to enter a date. | Cessation: | Click or tap to enter a date. |
|  | | | |
| Language of course instruction: | | Click or tap here to enter text. | |
|  | | | |
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|  | | | |

1. **Additional professional qualifications**

To duplicate the below table please click inside the box and select the ‘**+**’ icon on the bottom righthand side.

This can be repeated as many times as required to provide all information.

**Name of education institute:**

Click or tap here to enter text.

**Address:**

Click or tap here to enter text.

**Website:**

Click or tap here to enter text.

**Name of course:**

Click or tap here to enter text.

**Course commencement:**  Click or tap to enter a date.

**Course cessation:**  Click or tap to enter a date.

**Course details:**

Click or tap here to enter text.

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| **Section 3: Professional experience** |

Provide details of every work experience since qualification and list in order commencing with your current position. You must submit a Form B Reference for every work experience you wish to have considered as part of your application**.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| Your current position: | | Click or tap here to enter text. | | |
|  | | | | |
| Name of employer: | | Click or tap here to enter text. | | |
|  | | | | |
| Employer address: | | Click or tap here to enter text. | | |
|  | | | | |
| Contact name: | | Click or tap here to enter text. | | |
|  | | | | |
| Contact job title: | | Click or tap here to enter text. | | |
|  | | | | |
| Contact email: | | Click or tap here to enter text. | | |
|  | | | | |
| Duration of post: | Years Click or tap here to enter text. | | Months Click or tap here to enter text. | |
|  | | | | |
| Hours worked per week: | | Click or tap here to enter text. | | |
|  | | | | |
| Commencement: | Click or tap to enter a date. | Cessation: | | Click or tap to enter a date. |
|  | | | | |
|  | | | | |
| **That position was subject to regulation by the following competent authority or regulatory body**  **(if appropriate):** | | | | |
|  | | | | |
| Name of regulatory body or competent authority: | | Click or tap here to enter text. | | |
|  | | | | |
| Address: | | Click or tap here to enter text. | | |
|  | | | | |
| Email: | | Click or tap here to enter text. | | |
|  | | | | |
| Website: | | Click or tap here to enter text. | | |
|  | | | | |
| Registration number (or equivalent): | | Click or tap here to enter text. | | |
|  | | | | |
| **Provide a full account of your roles & responsibilities, typical work settings and details of how you are authorised to practice e.g., independently using guidelines or under medical practitioner license/instructions:**  Click or tap here to enter text. | | | | |

**Previous positions**

To duplicate the below table please click inside the box and select the ‘**+**’ icon on the bottom righthand side.

This can be repeated as many times as required to provide all information.

**Previous position:**

Click or tap here to enter text.

**Name of employer:**

Click or tap here to enter text.

**Employer address:**

Click or tap here to enter text.

**Contact name:**

Click or tap here to enter text.

**Contact job title:**

Click or tap here to enter text.

**Contact email:**

Click or tap here to enter text.

**Duration of post:**

**Years** Click or tap here to enter text. **Months** Click or tap here to enter text.

**Hours worked per week:**

Click or tap here to enter text.

**Commencement:** Click or tap to enter a date. **Cessation:** Click or tap to enter a date.

**That position was subject to regulation by the following competent authority or regulatory body**

**(if appropriate):**

**Name of competent authority or regulatory body:**

Click or tap here to enter text.

**Address:**

Click or tap here to enter text.

**Email:**

Click or tap here to enter text.

**Website:**

Click or tap here to enter text.

**Registration number (or equivalent):**

Click or tap here to enter text.

**Provide a full account of your roles & responsibilities, typical work settings and details of how you are authorised to practice e.g., independently using guidelines or under medical practitioner license/instructions:**

Click or tap here to enter text.

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| **Section 4: Declaration** |

**Please read through the following statements and tick the boxes to declare and note that:**

|  |  |  |
| --- | --- | --- |
|  | | |
| The information given in this application is true and accurate to the best of my knowledge and belief | |  |
|  | | |
| I have read the PHECC guidance on the website including the relevant Education Standards and Competency Framework | |  |
|  | | |
| I hereby consent and give authority to PHECC to make any enquiry or enquiries within any organisation, body or person in pursuance of my application for recognition of my professional qualifications in Ireland | |  |
|  | | |
| Signed: |  | |
| Please insert signature image or alternatively please print signatory page and sign before returning by email to [recognitionqualifications@phecc.ie](mailto:recognitionqualifications@phecc.ie) | | |
|  | | |
| Date: Click or tap to enter a date. | | |
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**DATA PROTECTION**

By submitting this form, you consent to PHECC holding and processing your personal data for the purpose of this application. In compliance with the Data Protection Acts 2018 (and subsequent 2019 amendments) & GDPR Regulations when PHECC is provided with personal data we will hold the data securely and confidentially for the purpose of assessing your professional qualifications. PHECC may also use the data provided for communication purposes with you. PHECC will make every effort to ensure that your data is correct however, if any of my data is incorrect or inaccurate, please inform PHECC in writing (email acceptable). A copy of your data currently held by PHECC may be obtained

upon written request to Pre-Hospital Emergency Care Council, Assessment of Qualifications Section, 2nd Floor Beech House, Millennium Park, Osberstown, Naas, Co. Kildare, W91 TK7N, Ireland.

**Version history**

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| --- | --- | --- |
| **Version** | **Date** | **Details** |
| 1 | Jan 2013 | New document |
| 2 | Dec 2014 | Form updated |
| 3 | April 2022 | Form updated |