

Questionnaire to accompany applications for the following Postgraduate Nursing Courses:

Graduate Certificate (NS32), Graduate Diploma (NS64) and Masters nursing course applicants (NS85) please complete page 1

Nurse Practitioner applicants (NS86) please complete page 2

This section needs to be completed by applicants applying for NS32, NS64 & NS85

Name of applicant: _____

Semester of commencement (e.g. Semester 2, 2010): _____

Study Area (e.g. Intensive Care Nursing) _____

1. Present position: _____

2. Organisation (or name of hospital): _____

3. Commencement date: _____

4. Ward/Unit: _____ Specialty: _____

Years Experience in Specialty: _____ (year commenced in specialty _____)

5a. Employment status (please circle): Full-time/Part-time 5b. if part-time state number of hours per week: _____

6. Ward/unit Nurse Educator **OR** Unit Manager Contact details:

Name: _____

Telephone: _____ Email: _____

If your Study Area is Paediatric and Child Youth Health, please nominate if you will be specialising in

Acute Paediatric Nursing or **Community, Child and Youth Health Nursing**

The Acute Paediatric Nursing Study Area requires evidence of current employment in a paediatric nursing setting which must be included with your application.

Community Child and Youth Health Nursing has a clinical practicum in semester 2. Students undertaking this stream should email the Student Information Centre at nursing.enquiries@qut.edu.au for more information.

Questionnaire to accompany applications for NS86 Master of Nursing Science (Nurse Practitioner)
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Present position: _____

Organisation (name of hospital/facility): _____

Specialty Area: _____

Years Experience in Specialty: _____ (year commenced in specialty _____)

Have you supplied the following in support of your Masters of Advanced Nursing Science (Nurse Practitioner) application?

- Letter of support from Executive Director of Nursing (or equivalent)
- Letters of support from two (2) members of your clinical support team.

Please give details of both your clinical support team members and your Director of Nursing (below)

Clinical Support Team member 1

Name & Title: _____

Position: _____

Location: _____

Address: _____

Phone: _____ Email: _____

Clinical Support Team member 2

Name & Title: _____

Position: _____

Location: _____

Address: _____

Phone: _____ Email: _____

Director of Nursing:

DON Name: _____

DON Address: _____

Email: _____