IRISH SOCIETY OF CHARTERED PHYSIOTHERAPISTS

Royal College of Surgeons in Ireland, 123 St Stephens Green, Dublin 2

Tel: (01) 402 2148 Fax: (01) 402 2160 Email: info@iscp.ie Website: www.iscp.ie

APPLICATION FORM

for

RECOGNITION of PHYSIOTHERAPY QUALIFICATIONS

acquired outside the REPUBLIC of IRELAND

Do NOT complete this form without reading the Application Form Manual & FAQ Booklet

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Sections 1, 3 and 4: Should be completed fully by the applicant.

Section 2: Should be completed by a member of the educational institute where undergraduate/pre-registration training was completed.

Section 5: Should be completed by your current/most recent employer, whom has been involved with your work in a supervisory capacity.

Note:

- Applicants are required to produce ***evidence of change of name*** e.g. photo ID with marriage certificate. These copies must be certified copies of the original.

- ALL forms and letters pertaining to membership must be completed in ***English.*** If submitted in their original language, they must be accompanied with a ***certified English translation***.

SECTION 1

PERSONAL DETAILS

First Name: _____ Surname: _____

Address: _____

_____

_____

City: _____ Country: _____

Phone: _____ Fax: _____

E-Mail: _____ Nationality: _____

Date of Birth: _____ (dd/mm/yyyy)

EDUCATIONAL INSTITUTION – UNDERGRADUATE/PRE-REGISTRATION

Name: _____

Address: _____

_____

City: _____ Country: _____

Phone: _____ Fax: _____

E-Mail: _____

Educational Award: (e.g. Degree, Dip.) _____

Course Title: (e.g. B. Sc. in Physio. etc.) _____

Date of Qualification: _____ (mm/yyyy)

Length of Course: _____ (years)

EDUCATIONAL INSTITUTION – FURTHER EDUCATION

Please complete below if you have obtained a Masters/Ph.D. Similarly, please inform us of your initial undergraduate course if you have completed a pre-registration course, regardless of whether it is physiotherapy-related.

Name: _____

City: _____ Country: _____

Educational Award: (e.g. Masters, Ph.D.) _____

Course Title: (e.g. M. Sc. in Physio. etc.) _____

Date of Qualification: _____ (mm/yyyy)

Length of Course: _____ (years)

SECTION 2

UNDERGRADUATE PHYSIOTHERAPY EDUCATION

Only this part of Section 2 to be completed by the applicant:

Name: _____ Surname: _____

Name of 3rd Level Institution: _____

Student I.D. No.: _____

Date of Birth: _____ (dd/mm/yyyy)

Applicant's Signature: _____

INSTRUCTIONS TO ACADEMIC INSTITUTION FOR COMPLETION:

Please be informed that the above named applicant has applied to the Irish Society of Chartered Physiotherapists (ISCP) for recognition of their physiotherapy qualifications. The ISCP is the designated authority for the recognition of qualifications in Ireland, acting with approval of the Minister for Health & Children. Applicants are required to have their qualifications recognised by the ISCP before being considered for employment in the Irish public health system. Supplemental information may be submitted in support of applicants claim; however, this document must be completed as comprehensively as possible in the format provided.

1. The Academic Institution Course Form may be completed by the Physiotherapy Programme Director or the Dean. The applicant cannot complete the form.
2. Each page of the Academic Institution Course Form has to be signed, dated and stamped by the Programme Director or the Dean.
3. Each page of Section 2 (pages 4 - 13) relating to undergraduate training must include a **comprehensive list of conditions treated** and the **physiotherapy treatment techniques, modalities and concepts utilised**.
4. The Committee does not accept codes or the term 'appropriate techniques'.
5. Section 2 E: Clinical Internship Form is not always applicable. If this section does not apply to you please return it stating "not-applicable" on the relevant page with the applicants name at the top.
6. Supervised Clinical Hours for Section 2 must be an accurate reflection of the time spent in the clinical setting.
7. If the university does not hold the records for clinical placements i.e. Section 2D, the applicant can complete these pages, however, the university must sign and stamp each page to validate the applicant's information.
8. Please ensure that there is no overlap of clinical hours, as the Committee will not accept this.

SECTION 2 A: FIELDS OF ACTIVITY - ACADEMIC & PRACTICAL

NAME OF APPLICANT: _____

SUBJECT	ACADEMIC (Hours)	PRACTICAL (Hours)	ECTS*
Anatomy			
Physiology			
Physics			
Chemistry			
Behavioural Science/Psychology/Sociology			
Pathology			
Orthoses/Prostheses			
Research Methods			
Electrotherapy			
Mobilisations/Manipulations			
Massage			
Movement Studies			
Assessment/Evaluation/Clinical Reasoning			
Hydrotherapy			
Legal/Ethical/Professional Issues			
Other (please specify):			
Total Hours:			
Office Use Only:			

***European Credit Transfer System** – please note total course credits assigned to each subject, if appropriate.

NAME:_____ **SEAL OF INSTITUTION:**

Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SIGNATURE: _____ **DATE:** _____

SECTION 2 B: FIELDS OF ACTIVITY - ACADEMIC & SUPERVISED CLINICAL

NAME OF APPLICANT: _____

SUBJECT	ACADEMIC (Hours)	SUPERVISED CLINICAL (Hours)	ECTS*
Musculoskeletal/Orthopaedics/Rheumatology			
Cardiorespiratory – Medical & Surgical			
Neurology – Medical, Surgical & Spinal Injuries			
Physical & Sensory Disability			
Women's Health			
Child Health			
Age Related Health Care			
Occupational Health/Ergonomics/Health & Safety			
Vascular Surgery & Rehabilitation of Amputees			
Mental Health			
Other (please specify):			
Total Hours:			
Office Use Only:			

***European Credit Transfer System** – please note total course credits assigned to each subject, if appropriate.

NAME:_____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE: _____

SECTION 2 A & B: FIELDS OF ACTIVITY - ADDITIONAL COMMENTS

NAME OF APPLICANT: _____

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 C: AUTONOMY & SCOPE OF PRACTISE

NAME OF APPLICANT: _____

	YES*	NO*
1. Do you prepare your students for:		
a. Direct access to patient/client?	❑	❑
b. Access on medical referral or other referral?	❑	❑
c. Access on prescription with freedom to decide intervention modality?	❑	❑
d. Access on prescription with an imposed intervention plan?	❑	❑

2. Subsequent to concluding supervised clinical hours and prior to the final examination, would you consider your student capable of: -

	CARDIORESPIRATORY		MUSCULOSKELETAL		NEUROLOGY	
	Yes*	No*	Yes*	No*	Yes*	No*
a. Assessing patients/clients, including appropriate clinical reasoning						
b. Planning appropriate treatment intervention						
c. Implementing treatment and/or intervention						
d. Implementing effective discharge planning						

Please tick as appropriate

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 C: AUTONOMY & SCOPE OF PRACTISE

NAME OF APPLICANT: _____

	YES*	NO*
3. Subsequent to concluding supervised clinical hours and prior to the final examination, would you consider your student capable of considering and implementing health care in the following fields:		
a. Health Promotion	❑	❑
b. Prevention of Injury	❑	❑
c. Education of Patients and/or Carers	❑	❑
4. As part of the undergraduate/pre-registration course in your institution, has this applicant completed and submitted a research project?	❑	❑

Title of Research Project: _____

_____

_____

5. Is the physiotherapy course in your institution accredited?	❑	❑	

If yes*, by whom

Professional Body	❑	Ministry of Health	❑
Ministry of Education	❑	University	❑
State Registration Board	❑	External Examiners	❑

Other *(please specify)*

_____

_____

******Please tick as appropriate*

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 D1: CLINICAL PRACTISE IN CARDIORESPIRATORY CARE

NAME OF APPLICANT: _____

HOSPITAL/CLINIC (Name/Address/e-mail address)	DATES FROM/TO (dd/mm/yyyy)	TOTAL NO. HRS	CONDITIONS TREATED	PHYSIOTHERAPEUTIC TREATMENT TECHNIQUES, MODALITIES & CONCEPTS UTILISED
	Office Use Only:			

Please comment on assessment, diagnostic and clinical reasoning skills of the applicant:

_____

_____

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 D2: CLINICAL PRACTISE IN MUSCULOSKELETAL & RHEUMATOLOGY

NAME OF APPLICANT: _____

HOSPITAL/CLINIC (Name/Address/ e-mail address)	DATES FROM/TO (dd/mm/yyyy)	TOTAL NO. HRS	CONDITIONS TREATED	PHYSIOTHERAPEUTIC TREATMENT TECHNIQUES, MODALITIES & CONCEPTS UTILISED
	Office Use Only:			

Please comment on assessment, diagnostic and clinical reasoning skills of the applicant:

_____

_____

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 D3: CLINICAL PRACTISE IN NEUROLOGICAL REHABILITATION

NAME OF APPLICANT: _____

HOSPITAL/CLINIC (Name/Address/ e-mail address)	DATES FROM/TO (dd/mm/yyyy)	TOTAL NO. HRS	CONDITIONS TREATED	PHYSIOTHERAPEUTIC TREATMENT TECHNIQUES, MODALITIES & CONCEPTS UTILISED
	Office Use Only:			

Please comment on assessment, diagnostic and clinical reasoning skills of the applicant:

_____

_____

NAME: _____
Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SEAL OF INSTITUTION:

SIGNATURE: _____

DATE:

SECTION 2 D4: UNDERGRADUATE CLINICAL PRACTISE IN OTHER AREAS

Please state 'Not Applicable' on this page with the applicant's name, if appropriate.

NAME OF APPLICANT: _____

HOSPITAL/CLINIC (Name/Address/ e-mail address)	DATES FROM/TO (dd/mm/yyyy)	TOTAL NO. HRS	CONDITIONS TREATED	PHYSIOTHERAPEUTIC TREATMENT TECHNIQUES, MODALITIES & CONCEPTS UTILISED
	Office Use Only:			

Please comment on assessment, diagnostic and clinical reasoning skills of the applicant:

_____

NAME: _____ **SEAL OF INSTITUTION:**

Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SIGNATURE: _____ **DATE:**

SECTION 2 E: CLINICAL INTERNSHIP FORM

Please state 'Not Applicable' on this page with the applicant's name, if appropriate.

NAME OF APPLICANT: _____

HOSPITAL/CLINIC (Name/Address/ e-mail address)	DATES FROM/TO (dd/mm/yyyy)	TOTAL NO. HRS	CONDITIONS TREATED	PHYSIOTHERAPEUTIC TREATMENT TECHNIQUES, MODALITIES & CONCEPTS UTILISED
	Office Use Only:			

Please comment on assessment, diagnostic and clinical reasoning skills of the applicant:

_____

_____

NAME: _____ **SEAL OF INSTITUTION:**

Director of School/Institution or Authorised Deputy
BLOCK CAPITALS

SIGNATURE: _____ **DATE:**

SECTION 3

POST-QUALIFYING CLINICAL EXPERIENCE

NAME OF APPLICANT: _____

- Please describe your clinical experience to date, starting with the most recent, in chronological order. Please include, in this section, if you have been employed outside of the physiotherapy profession, have had a period of time traveling or a period of further study, career break or have been unemployed at any stage.
- The must be NO gaps in your employment.
- The 'field of activity' is the area of physiotherapy practise in which clinical experience was gained e.g. musculoskeletal, child health, neurology etc. Please expand if appropriate.
- Additional pages must be photocopied, if required.

Name of Institution: _____

_____

Address: _____

_____

City: _____ Country: _____

Position Held: _____

Supervisor: _____
(e.g. Manager/Senior)

Dates From/To: _____
(mm/yyyy)

Duration of Experience: _____

Field of Activity: _____

_____

_____

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SECTION 4

CONTINUING PROFESSIONAL DEVELOPMENT

NAME OF APPLICANT: _____

Please list courses that you have completed **since** your undergraduate/pre-registration physiotherapy education. **You must send a certified copy of all awards listed below**. If you have completed a Masters/Ph. D., please include a transcript also.

The courses should be identified as either:

a. Validated Advanced Professional Education
Term reserved for those courses that lead to the award of title/diploma accredited by the profession[1].

b. Post-Graduate Education
Term reserved for those activities that lead to the award of a higher academic title/degree awarded by a University of Higher Education Institution[1] e.g. M.Sc. Ph. D.

c. Short Courses
Anything else.

TITLE OF COURSE	INSTITUTION	DURATION & DATES	TYPE (A)*	TYPE (B)*	TYPE (C)*

- *Please tick as appropriate.
- Please photocopy further pages as necessary
- [1] 'The Practise of Physiotherapy in the European Community'. Standing Liaison Committee of Physiotherapists within the European Union (SLCP) – September 2006.

SECTION 5

CLINICAL REFERENCES (POST QUALIFICATION)

NAME OF APPLICANT: _____

- If you have worked or are currently working as a volunteer please ask that a supervisor or manager complete this reference.
- References completed by a relative would not be considered as a valid reference.

REFEREE'S INSTRUCTIONS:

- Please be informed that the above named applicant has applied to the Irish Society of Chartered Physiotherapists (ISCP) for recognition of physiotherapy qualifications in the republic of Ireland. The ISCP is the designated authority for the recognition of the qualification of physiotherapy, acting with approval of the Minister for Health. In order to assist in completing the assessment, please complete the following reference in full.
- Two (2) references are required. One from your current/most recent physiotherapy manager and the other from a physiotherapist who has supervised you in clinical practise.
- References need to be completed, signed, dated and stamped by the referee.
- If your referee does not have a stamp, a current business card or letterhead would suffice.
- References must be returned to the applicant in a sealed envelope with the referee's signature over the seal.
- References must be written in English or translated by a certified translator <u>in the same format as below.</u>

1. Name of Applicant: _____

2. Name of Referee: _____
   - Title (incl. qualification) _____
   - Address _____
     _____
     _____
   - Tel. No.: _____
   - Fax. No.: _____
   - e-mail: _____

2. In what capacity do you know the applicant? (manager, supervisor, colleague)

   _____

3. Clinical Location: (relating to the applicant)
   - Name: _____
   - Address: _____
     _____
     _____
   - Nature of Business: _____
     (e.g. acute care, private practice etc.)

SECTION 5 CLINICAL REFERENCES (POST QUALIFICATION)

NAME OF APPLICANT: _____

5. Title of Position Held: _____

6. Duration of Employment:

- Date From: _____ (mm/yyyy) Date To: _____ (mm/yyyy)

7. Please specify hours worked per week: _____hrs Full-Time/Part-Time

8. Clinical areas in which the candidate worked: Duration: (e.g. wks/mths)

- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____

9. Please indicate patterns of clinical referral in your physiotherapy service.

Do you normally treat patients by:	YES*	NO*
• Patients referred by doctor		
- Diagnosis and treatment indicated by referral	❑	❑
• Patients referred by doctor		
- Physiotherapist diagnoses and selects treatment modalities	❑	❑
• Patient self-refers		
- Physiotherapist diagnoses and selects treatment modalities	❑	❑

Please tick as appropriate

NAME OF APPLICANT: _____

10. Please outline the range of physiotherapy conditions commonly assessed and treated by the applicant and physiotherapy concepts and modalities utilised.

_____

11. Please rank the applicant's assessment and diagnostic skills:

Poor ❑ Satisfactory ❑ Good ❑ Excellent ❑

SECTION 5 CLINICAL REFERENCES (POST QUALIFICATION)

NAME OF APPLICANT: _____

12. Please comment on applicant's ability to apply clinical reasoning methods to patient management

13. Please comment on the applicant's ability to design, implement, and modify treatment plans through to effective discharge.

SECTION 5 CLINICAL REFERENCES (POST QUALIFICATION)

NAME OF APPLICANT: _____

14. Has the applicant contributed to Continuing Professional Development (CPD) within the department? Please give details e.g. in-services, quality initiatives, staff appraisals etc.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

15. Any other factors relevant to the applicant.

_____
_____
_____
_____
_____
_____
_____

I declare that the above information given in this reference is true and accurate.

NAME: _____ ***STAMP:**
BLOCK CAPITALS

SIGNATURE: _____ **DATE:**

Please remember to place in an envelope and sign across the seal.

****If you do not have a clinic/ hospital stamp please include a business card or letter head***

DATA PROTECTION STATEMENT

The Irish Society of Chartered Physiotherapists will process your personal information in accordance with the Data Protection Acts (1988 and 2003). The information you have provided will be used and held by the ISCP to process your application and will be part of your membership record. It is the obligation of the Irish Society of Chartered Physiotherapists to collect and record certain personal data relating to each member. This will include names, addresses and qualifications of members. Such data may also contain information with regard to the conduct of the member in carrying out professional duties in accordance with the regulatory procedures of the Irish Society of Chartered Physiotherapists. You have a right to request personal data about yourself in writing and to correct the same if it is incomplete or misleading.

The ISCP has adequate measures to ensure that your information is held securely. Academic institutions and students that are looking to contact members to participate in research studies occasionally approach the ISCP. The ISCP is also occasionally approached by commercial bodies offering preferential rates to ISCP members for various products and services. Once a clear benefit to members has been identified the Executive Board passes the information to its members.

Please tick here if you do not want us to use your contact details in this way ❑

PRIVACY WAIVER

In accordance with European Directive (2005/36/EC) on the Recognition of Professional Qualifications, the ISCP is obliged to exchange information regarding disciplinary action or criminal sanctions taken or any other serious circumstances, which are likely to have consequences for pursuit of activities under this Directive. Personal data may be used in a number of circumstances such as:

The furnishing of information relating to the good standing of a member of the society to Irish Government Agencies, Foreign Government Agencies/Professional Bodies, including recording information with regard to conduct or professional indemnity of the member. The context in which the information is required is almost exclusively in the context of employment or appointment to posts or positions.

N.B: BY SIGNING THE DECLARATION STATEMENT YOU ARE GIVING YOUR CONSENT FOR THE DISCLOSURE OF INFORMATION

DECLARATION STATEMENT

If an applicant gains registration with the ISCP on the basis of incorrect information he/she may thereby gain a pecuniary advantage by deception, which may constitute a criminal offence. Inadvertent misrepresentation of information may imperil members of the public who will place a potentially unfounded faith in the skills of the practitioner. The onus for ensuring the full and accurate disclosure of information rests with the applicant.

Treatment of patients for which the practitioner does not have the necessary competence is defined as infamous conduct under the ISCP Rules of Professional Conduct, and could lead to steps being taken resulting in the practitioner being struck off and rendered ineligible to practise the regulated profession.

- **I declare** that the information given in this document and in all attached forms is true and accurate.
- **I declare** that I have not made a previous application for registration, and that I have read, understood and agree to abide by the Society's Rules of Professional Conduct.
- **I declare** that in NO circumstances, have I been engaged in any misconduct within the scope of my profession as a physiotherapist
- **I declare** that I am fit to carry on the practise of physiotherapy in the language or vernacular of the area of the Republic of Ireland where I intend to practise.
- **I understand** that failure to disclose full information, or any deliberate misrepresentation of information, is a serious matter and will invalidate my application.
- **I agree** to notify the Society, in writing, of any change of personal details, e.g. change of surname or address, as and when any such change occurs.

Signature of Applicant: _____

Date: _____

CREDIT CARD/LASER CARD PAYMENT DETAILS

Name of Card Holder: _____
(BLOCK CAPITALS)

Card Holder's Address: _____

_____

_____

_____

PAYMENT METHOD (Cheques / Drafts / Money Orders must be in Euro and made payable to the ISCP)

Card Option: Laser Card ☐ VISA Debit Card ☐ *VISA ☐ * MasterCard ☐

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐

(SECURITY NUMBER) ☐☐☐ Expiry Date: ☐☐ ☐☐

Payment	**€**
Plus 2.5% charge for credit card transaction	**€**
Total Payment	**€** _____

**** Please note that there is an additional charge of 2.5% for credit card transactions. There is no extra charge for laser or debit card transactions.***

Security Number: -last three digits on the back of card

I hereby authorise you to debit my credit card/debit card as set out above.

Signature: _____

Date: _____

APPLICATION FORM CHECKLIST

for

RECOGNITION of PHYSIOTHERAPY QUALIFICATIONS

acquired outside the REPUBLIC OF IRELAND

Do NOT complete this form without reading the Application Form Manual & FAQ Booklet

o Avoid Delays, Please Ensure That You Forward All of the Following:	YES	NO
I have enclosed a completed application form.	☐	☐
I have enclosed the Academic Course Information Form with my name, date, official stamp from my educational institution and the signature of the Head/Dean of School of Physiotherapy on each page. (Section 2: pp 3 -13 inclusive)	☐	☐
I have enclosed two clinical references, which have been stamped, dated signed and sealed in an envelope. The referee's signature is across the seal. (Section 5: pp 16 - 20)	☐	☐
I have enclosed a certified copy of my Physiotherapy Qualification (eg Certificate/Diploma/Degree).	☐	☐
I have enclosed a certified copy of my University Transcript	☐	☐
I have enclosed certified proof of eligibility to practise in the country in which my physiotherapy qualifications were obtained.	☐	☐
I have enclosed a legible copy of a certified current registration card/certificate from the registering authority in the country where the applicant is currently practising. If registration is not compulsory, a current membership card/membership certificate/letter of eligibility for membership from the professional body is enclosed.	☐	☐
I have enclosed a certificate of current professional status (otherwise known as a letter of good standing) from the registering authority or professional body of the country where the applicant most recently practised as a physiotherapist, if membership has lapsed or if the registering authorities/professional body offers life membership.	☐	☐
I have enclosed a certified copy of my current passport - showing the expiry date	☐	☐
I have enclosed the non-refundable application fee of €500	☐	☐
I have signed and dated the Declaration Statement.	☐	☐