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|  | ***WESTERN AUSTRALIA NURSING SERVICE MEDAL***  ***APPLICATION FORM*** |

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| **Surname:** | | **First Name:** | **Middle Name:** |
| **Date Of Birth:** | **Registration No :** **Nursing Category:** | | |
| ***CONTACT DETAILS:***  **Address:** | | | |
| **Phone No:** | | **Email:** | |
| ***WORK HISTORY***  Where possible, please attach any supporting documentation such as Certificate of Service that may assist in verifying commencement and cessation dates. | | | |
| **NURSING TRAINING:** | | | |
| **Hospital Based**  **Date training commenced:**  **University/TAFE**  **Date training ceased:** | | | |
| **Name of training organisation:** | | | |
| **Date Registered within Western Australia:**  **Current employment status (please tick):**  **Current**  **Medical Retirement**  **Resignation**  **Posthumous Application**  **Retirement**  **Other** | | | |
| **Current employer:** | | | |

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| **POST REGISTRATION EXPERIENCE**  **(Please ensure that we at least have the month as well of the year)** | | | | | | | | |
| **HOSPITAL** | **CAPACITY IN WHICH EMPLOYED** | **FROM**  **Both month & Year** | | | **TO**  **Both month & Year** | | | **EXPERIENCE IN YEARS** |
| **Sample Hospital** | **EN** |  | **MM** | **YYYY** |  | **MM** | **YYYY** |  |
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| **POST REGISTRATION EXPERIENCE (Continued)** | | | | | | | | | | |
| **HOSPITAL** | **CAPACITY IN WHICH EMPLOYED** | **FROM** | | | **TO** | | | | **EXPERIENCE IN YEARS** |  |
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| **TOTAL YEARS OF NURSING SERVICE** | | | | | | | |  | | |

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| **Signature:** | **Date:** / / \_ |

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| **Honours and Awards Use Only** | | |
| **Acknowledgement sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Entered on Schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Confirm Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Confirm Cessation date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Student Service: Yes**  **No** | **Confirm Student Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Ethical & Diligent Service: Yes**  **No** | **Integrity Check: Yes**  **No** | |
| **Eligible: Yes**  **No** |  |  |
| **Presentation Advice Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date Fwd \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_** |  |
| **Medal  15 yr  20 yr  25 yr  30 yr  35 yr  40 yr  45 yr **  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

*Forward the completed application form for consideration to:*

*Medals for Nurses*

*PO Box 1157*

*Kelmscott DC WA 6997*