Nursing Competency Assessment Programme

Doctor's Name:

Doctor's Qualifications (Official stamp (if any))

Doctor's Address:

Doctor's phone number:

Doctor's Email address:

Declaration:

Based on examination of (*applicant name*) …….. of (*address*)……..…medical history and patient record and interpretation of immune status results (including Xray result* if required) I find that (*applicant name*) …….. poses no risk to self or patients by undertaking practical work experience/nursing in an acute/tertiary/community healthcare institution in New Zealand

Signature:

Medical Practitioner Name:

Date:

(NOTE: This form is to be signed by the doctor only)

*Xray only indicated where Quantiferon TB-Gold test positive