



Ministry of Health- Nursing Division

To establish your professional nursing status, please provide the full extent of your curriculum of nursing study and training.

Instructions: Fill out Part I of this form. An official authority in your nursing school should complete part II and send it directly to the Nursing Division, Ministry of Health, Israel.

Section I: Applicant`s details

NAME AND ADDRESS:

Name :

First/Given Name Middle Name Family Name/Surname

Maiden Name :

Mailing Address :

Date of Birth: _____ Marital Status: S M W D

Month Day Year

Israeli ID number _____ :

GENERAL EDUCATION:

Years of Primary Schooling: _____ Years of Secondary Schooling _____ :

Total Years of Schooling before Nursing School _____ :

Year finished Secondary School _____ :



NURSE TRAINING:

Name and Address of School of Nursing :

Date Entered: _____ Date Graduated _____ :

Give full name of award :

Circle, which of the following areas of nursing theory and practice were included in your nursing curriculum:

Medical Surgical Obstetric Pediatric Psychiatric Public

Note: If you attended more than one, school to study these 6 areas of nursing, photocopy Part II of this form and send a copy to each school.

NURSING LICENCE:

Give the full title of your occupation as it appears on your Nursing License:

Did you pass an examination to get this license? (Circle One per Row)

Yes

No

ADVANCED TRAINING:

Subject: _____ Length of Course _____ :

Signature of Applicant _____ :



Section II: Program details and training program

To the Head of the nursing program: We ask you to complete this form regarding the applicant who has applied to register as a nurse with the Israel Nursing Division. You should complete all sections of the form.

The Director, Registrar, or Chief Nurse of the School of Nursing should complete part II and send it directly to the Nursing Division, Ministry of Health, Israel.

Name of Student: _____

Name of School of Nursing:

Address of School of Nursing:

E-mail Address of School of Nursing:

Date Student Admitted: _____ Date Graduated: _____

Month Year

Month

Year Length of the studies (how many semesters) _____

Passing grade _____ out of _____

Number of failures permitted during the studies _____

Please state here the key for converting timetable (clock) hours of theoretical study and clinical experience to credit points.

One credit point = ___ hours of theoretical study

One credit point = ___ hours of clinical practice

One credit point = ___ hours of simulation\lab experience



Please state here the total number of timetable hours for each of the following components:

Hours of theoretical study ____

Hours of clinical practice\bed side practice ____

Hours of simulation\lab experience ____

Please state here if the studies were On- line \distance\E- learning? (Circle One)

Yes

NO

If stated "yes" please state for how long (the total number of timetable hours)

Please explain which topics\subjects has been studied **on line\ distance\ e-learning:**



DETAILED CURRICULUM --- THEORY AND PRACTICE

Please provide specific theory and clinical timetable hours for all nursing domains and subject areas listed below. **Do not** combine the nursing domains or subject areas/ if they combined in your curriculum please state an estimation of the theory and clinical hours in each nursing domain. Don't leave any blanks enter **N/A** if not applicable

Nursing Domains	Timetable (Clock) Hours	
	Theory (class) hours attained	Clinical practice (bed side) hours attained (do not include lab\simulation)
Chemistry and Biochemistry		
Anatomy and Physiology		
Microbiology		
Nutrition		
Pharmacology		
Physical Assessment		
The Problem-Solving Process in Nursing		
Communications & Interviewing		
Clinical Skills & Exceptional Procedures		
Adult medical Nursing		
Adult surgical Nursing		
Geriatric Nursing		
Pediatric Nursing		
Obstetric & Gynecological Nursing		
Public Health & Community Nursing		
Mental Health & Psychiatric Nursing		
Emergency & Trauma		
Total hours		



Nursing Domains	Date of Clinical Practice (d\m\y- d\m\y)	Total Clinical practice (Bed side) hours attained	Name and Place of the clinical field (ward)	Date of Simulation (d\m\y- d\m\y)	Total simulation\ lab hours attained
Adult Nursing (Medical)					
Adult Nursing (Surgical)					
Nursing Geriatrics					
Pediatric Nursing					
Obstetric & Gynecological Nursing					
Public Health & Community Nursing					
Mental Health & Psychiatric Nursing					
Emergency & Trauma					
Advance Training					
Other Training					
Total hours					

Full Name of Signatory: _____ Stamp/Seal

Signature _____ :

Title: _____ Date _____ :

Email: _____ Telephone number: _____