

## Application: To Become A Rural Midwife Mentor

	DETAILS OF THE RURAL MENTOR MIDWIFE
Midwifery Council Registrati	on Number:
NZCOM Membership Number:	
Or Name of Organisation Providin	g Indemnity:
Mentor Midwife Contact	Details:
Surname or Family Name:	
Christian (Given) Names:	
Preferred Name: Street Address:	
Suburb /RD #:	
City / Town:	
Phone:	
Mobile:	
E-mail:	
Sex: Female	Male Date of Birth:
NZ/European/Pakeha	New Zealand MaoriEuropeanIndianNiueanTokelauanSouth East AsianSamoanTonganChineseOther
Bank Account Number: (For Direct Credit purposes) GST Registered: Yes	$ \boxed{\begin{array}{c} \hline \\ \hline $
My GST Number is:	
	PRACTITIONER QUALIFICATIONS AND EXPERIENCE
Year of New Zealand Midwifery Registration:	
Country of Initial Registration:	UK Australia USA Europe
Asia	South Africa     Pacific     Other (specify)
Year of Initial Midwifery Regis	

Are you actively engaged in the Midwifery Council Recertification Programme? Yes / No

Please complete the questions below.



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Full name:	
Years of Practice: LMC	
Years of Practice: LMC	
Please describe your current and previous midwifery practice experience in primary, homebirth and rural settings:	
Why would you like to be Rural Mentor Midwife?	
Please describe your experience of mentoring:	
Have you attended and participated in the 'NZCOM Practicalities of Being a Mentor Midwife workshop'? Yes/ No Date attended: If No please contact RMRR at <u>rural@mmpo.org.nz</u> to register to attend.	
AVAILABILITY and COMMITTMENT	
I confirm that I am available and committed to enter a mentoring relationship for a negotiated time period to be decided with the mentored midwife once the partnership has commenced.	
CERTIFICATION	
<ol> <li>I certify the above information is true and correct. I am aware the information will be used in a matter consistent with the Health Information Privacy Code 1994.</li> </ol>	
<ol> <li>I confirm that I am not currently under Midwifery Council processes such as competency review or competence programme, there are no complaints or cases against me before the Health and Disability Commissioner the Midwifery Council, the Professional Conduct Committee, ACC or the Health Practitioners Disciplinary Tribunal</li> </ol>	
Signature of PRACTITIONER Date:	
HPAC Agreement Number:	