



HSCP PROFESSIONAL DEVELOPMENT FUNDING

EXPRESSION OF INTEREST FORM

(Please include the name of the course you are applying for in the subject header of the email when submitting your application.)	
Surname	
Email Address	
Profession	
Current Role	
Work Location:	
Please provide details of the organisation you	
work in and location	





Qualifications/Prior	CPD in the Area:
Statement of suppor	rt from Line Manager:
l,	, Line Manager to, support this
application, and if suc	cessfully funded, I will approve release of this staff member to participate as per the
course requirements.	
Signed:	Date:
(electronic signa	ature or wet ink (i.e. not typed)
Applicant Commitme	ent
	, acknowledge requirement, and commit to undertake, all aspects
required for completic	on of the course. Additionally, I commit to engage and work with the National HSCP
Office to evaluate th	e impact of my participation in this professional development opportunity on a
personal, service leve	el, and service-user perspective.
<u> </u>	
Signed:	Date:
•	your contact information on file for communication regarding future events or e National Health & Social Care Office, HSE. Please indicate below if you s to be held:
Yes, I consent	
No. I do not consent	