Wintec | Te Pūkenga

To whom it may concern:

In accordance with The Health Practitioners Competence Assurance Act 2003, 45 Subsection (5) if the Wintec midwifery manager has reason to believe a student who is entering the Bachelor of Midwifery programme would beunable to perform the functions required for the practice of the midwifery profession because of some mental or physical condition, the manager must notify the Registrar of Midwifery Council of NZ.

____ (students name) has been seen by me, and

☐ I declare that she/he has no known medical condition(s) (mental or physical) which will/may impact on her/his ability to practice safely in the clinical practice context.

or

☐ I declare that she/he has the following medical condition(s) (mental or physical) identified below and that they will not impact on her/his ability to practice safely in the clinical practice context., including medication.

____

____

and she/he is medically clear to attend full-time demanding study.

The student must also (please tick):

☐ Be able to stand, walk, stretch, twist, bend, lift/move weights up to and including 15 kilograms.
☐ Have manual dexterity sufficient to operate equipment and undertake record keeping.
☐ Have hearing/speech sufficient to communicate with clients and co-workers, enabling direct communication and telephone communication.
☐ Have visual ability sufficient to read, write and record information and sufficient to be able to operate and monitor equipment.
☐ Have the mental concentration to focus on tasks.
☐ Be able to function under rapidly changing and demanding conditions.
☐ Have an absence of a health condition which could increase their susceptibility if exposed to different chemicals or infections more frequently than expected with daily living.
☐ Have a level of fitness required for full-time work and/or full-time study.
☐ Does he/she have any skin conditions that may not allow frequent contact with water, soap, disinfectant and cleaning chemicals? If Yes, please provide further details

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Medical Practitioner Name: ______________________________
Medical Practice Name/Stamp:

Signature: ______________________________
Date: ______________________________