TÜVRheinland®
Precisely Right.

Initiative Chronische Wunden

Change notification for existing application

ICW/TÜV 2024

The change notification refers to education providers of wound seminars “ICW/TÜV” with valid recognition where there is a change in one of the following aspects.

Please send the notification of change as a EDP version and enclose any attachments. Send to: zert.leitung@icwunden.de

1. Master data

Data of the education and training institute (education provider)

✍ *please complete in block letters*

Provider number:			
Institute:			
Owner of the institute:			
Postal address:			
Country			
Location if applicable:			
Contact person:			
Phone:		**Fax**:	
Public e-mail:			
E-mail 2:			
Website:			

☞ ***Enter previous data!***

The notification refers to the existing application for the...

- ☐ Basic seminar Woundexpert ICW®
- ☐ Basic seminar Physician Woundexpert ICW®
- ☐ Advanced seminar Woundtherapist ICW®
- ☐ Advanced seminar Woundcare specialist ICW®

Certificate-No. (of the provider acknowledgement) valid until: _____

2. Modifications

Modification to be applied as from (date): _____

Modification refers to

- ☐ Basic data of the provider
- ☐ Cooperation
- ☐ Educational management
- ☐ Professional management
- ☐ Examination committee
- ☐ Other: _____

☞ *Details of the modifications requested: (enter only relevant changes!)*

Changed basic data of the provider

Name of the institute:			
Owner of the institue:			
Postal address:			
Country:			
Location if applicable:			
Contact person:			
Phone:		**Fax**:	
Public e-mail:			
E-mail 2:			
Website:			

Changed cooperation/new cooperation

New educational management

Name:	
First name:	
Basic qualification: ☐ Registered nurse	
☐ Other:	

Educational qualification:

☐ Teachers for nursing profession, medicine or nursing educator*
☐ Qualification certificates and professional biography are attached
☐ Proof/registration of participation in the management seminar "basics" (train the trainer)
☐ In case of application for the seminar Woundcare specialist ICW®/Woundtherapist ICW®: Participation documents of the corresponding trainer seminar are attached

✍*To be filled in by the educational management:*

☐ I confirm that I will carry out the educational management function of the requested seminar.		
Name:		Signature new educational management
Place:		
Date:		

***** *A pedagogical/educational qualification for nursing teacher according to the level 6 EQF (European qualification framework) is needed*

New deputy educational management

Surname:	
First name:	
Basic qualification: ☐ Registered nurse ☐ Physician (human med.)	
☐ Other:	

Educational qualification:

☐ Teachers for nursing profession, medicine or nursing educator*
☐ Qualification certificates and professional biography are attached
☐ Proof/registration of participation in the management seminar "basics" (train the trainer)
☐ In case of application for the seminar Woundcare specialist ICW®/Woundtherapist ICW®: Participation documents of the corresponding trainer seminar are attached
☐ Registered in the lecturers list

✍*To be filled in by the deputy educational managenment:*

☐ I confirm that I will carry out the educational management function of the requested seminar.		
Name:		Signature new deputy educational management
Place:		
Date:		

***** *A pedagogical/educational qualification for nursing teacher according to the level 6 EQF (European qualification framework) is needed*

New professional management

Surname:	
First name:	
Basic qualification: ☐ Registered nurse	
☐ Other:	

Professional qualification:

☐ Specialist qualification in the subject area of "chronic wounds" based on relevant practical professional knowledge/experience and further training(s) on the subject of chronic wounds completed with a recognised specialist association
☐ Certificates of qualifications and short professional biography attached
☐ Proof/registration of participation in the management seminar "basics" (train the trainer)
☐ When applying for the seminar Woundtherapist ICW®/Woundcare specialist ICW®: Proof of participation in the corresponding trainer seminar attached
☐ Registered in the lecturers list

✍ *To be filled in by the professional management:*

☐ I confirm that I will carry out the educational management function of the requested seminar.

Name:		Signature of the new professional management
Place:		
Date:		

New deputy professional management

Surname:	
First name:	
Basic qualification: ☐ Registered nurse	
☐ Other:	

Professional qualification:

☐ Specialist qualification in the subject area of "chronic wounds" based on relevant practical professional knowledge/experience and further training(s) on the subject of chronic wounds completed with a recognised specialist association
☐ Certificates of qualifications and short professional biography attached
☐ Proof/registration of participation in the management seminar "basics" (train the trainer)
☐ When applying for the seminar Woundtherapist ICW®/Woundcare specialist ICW®: Proof of participation in the corresponding trainer seminar attached
☐ Registered in the lecturers list

✍ *To be filled in by the deputy professional management:*

☐ I confirm that I will carry out the educational management function of the requested seminar.

Name:		Signature of the deputy professional management
Place:		
Date:		

Examination committee

☞ *Please enter the complete name of the current examination committee if changes have been made!*

Chairperson of the examination committee	
Surname:	
First name:	
☐ Qualifications listed in the lecturers list ☐ Certificates attached ☐ Certifcates available at the certification body	

Deputy chairperson of the examination committee	
Surname:	
First name:	
☐ Qualifications listed in the lecturers list ☐ Certificates attached ☐ Certifcates available at the certification body	

Lecturer	
Surname:	
First name:	
☐ Qualifications listed in the lecturers list ☐ Certificates attached ☐ Certifcates available at the certification body	

Deputy lecturer	
Surname:	
First name:	
☐ Qualifications listed in the lecturers list ☐ Certificates attached ☐ Certifcates available at the certification body	

Other

Name:		Signature Stamp of the education and training institute
First name::		
Place:		
Date:		

To be completed by the certification body:

☐ Change confirmed: Recognition and certification body, date: _____

☐ Modification rejected, date: _____

Reason:

Frankenau/Berlin	
Date:	
Name:	
Authorised signatory of the recognition and certification body	

