



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: <u>zert.leitung@icwunden.de</u>

1. Master data

Data of the education and training institute (education provider)

Z please complete in block letters

Provider number:		
Institute:		
Owner of the institute:		
Postal address:		
Country		
Location if applicable:		
Contact person:		
Phone:	F	ax:
Public e-mail:		· ·
E-mail 2:		
Website:		
Enter previous da	ta!	

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

	Basic seminar Woundexpert I	CW®
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- 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:

The second seco

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

Changed basic data of the provider

Changed cooperation/new cooperation

New educational management

Name:	
First name:	
Basic qualificat	tion: Registered nurse
□ Other:	
Educational gualification:	

□ 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

zTo 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:	Other:		
Educational qu	alification:		
□ Teachers for r	nursing profession, medicine or nursing educator*		
Qualification certificates and professional biography are attached			
\Box 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 qualificat	tion: Registered nurse	
□ Other:		
Professional qu	ualification:	
 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	

Solution 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 qualificat	tion: Registered nurse
□ Other:	
Professional qu	ualification:
professional wounds com	alification in the subject area of "chronic wounds" based on relevant practical knowledge/experience and further training(s) on the subject of chronic pleted with a recognised specialist association f qualifications and short professional biography attached
□ When applyin	tion of participation in the management seminar "basics" (train the trainer) g for the seminar Woundtherapist ICW [®] /Woundcare specialist ICW [®] : Proof of
	in the corresponding trainer seminar attached the lecturers list

Z To be filled in by the deputy professional management:

□ I confirm that I will carry out the educational management function of the requested semi-		
nar.		
Name:		Signature of the deputy professional manage- ment
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 □ Certificates available at the certification body 		
Deputy chairperson of the examination committee		

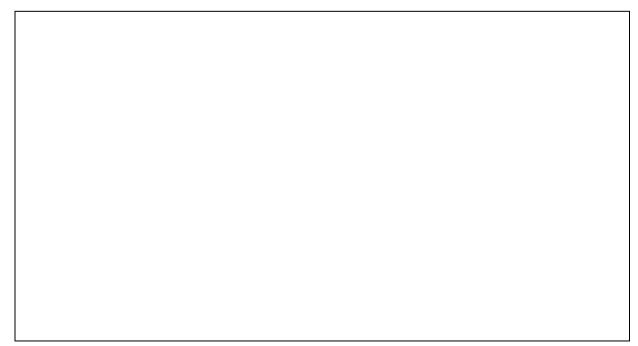
Deputy chairperson of the examination committee	
Surname:	
First name:	
Qualifications listed in the lecturers list	

 $\hfill\square$ Certificates attached $\hfill\square$ Certificates available at the certification body

Lecturer			
Surname:			
First name:			
Qualifications listed in the lecturers list			
\Box Certificates attached \Box Certificates available at the certification body			
Deputy lecturer			

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

Other



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