

Change notification for existing application

**ICW/TÜV
2026**

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 institute:			
Postal address:			
Country:			
Location if applicable:			
Contact person:			
Phone:		Fax:	
Public e-mail:			
E-mail 2:			
Website:			

Changed cooperation/new cooperation

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New educational management

Name:	
First name:	
Basic qualification: <input type="checkbox"/> Registered nurse	
<input type="checkbox"/> Other:	
Educational qualification:	
<input type="checkbox"/> Teachers for nursing profession, medicine or nursing educator* <input type="checkbox"/> Qualification certificates and professional biography are attached <input type="checkbox"/> Proof/registration of participation in the management seminar "basics" (train the trainer) <input type="checkbox"/> 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:

<input type="checkbox"/> 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: <input type="checkbox"/> Registered nurse <input type="checkbox"/> Physician (human med.)	
<input type="checkbox"/> Other:	
Educational qualification:	
<input type="checkbox"/> Teachers for nursing profession, medicine or nursing educator* <input type="checkbox"/> Qualification certificates and professional biography are attached <input type="checkbox"/> Proof/registration of participation in the management seminar "basics" (train the trainer) <input type="checkbox"/> In case of application for the seminar Woundcare specialist ICW®/Woundtherapist ICW®: Participation documents of the corresponding trainer seminar are attached <input type="checkbox"/> Registered in the lecturers list	

To be filled in by the deputy educational management:

<input type="checkbox"/> 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: <input type="checkbox"/> Registered nurse	
<input type="checkbox"/> Other:	
Professional qualification:	
<input type="checkbox"/> 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 <input type="checkbox"/> Certificates of qualifications and short professional biography attached <input type="checkbox"/> Proof/registration of participation in the management seminar "basics" (train the trainer) <input type="checkbox"/> When applying for the seminar Woundtherapist ICW®/Woundcare specialist ICW®: Proof of participation in the corresponding trainer seminar attached <input type="checkbox"/> Registered in the lecturers list	

To be filled in by the professional management:

<input type="checkbox"/> 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: <input type="checkbox"/> Registered nurse	
<input type="checkbox"/> Other:	
Professional qualification:	
<input type="checkbox"/> 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 <input type="checkbox"/> Certificates of qualifications and short professional biography attached <input type="checkbox"/> Proof/registration of participation in the management seminar "basics" (train the trainer) <input type="checkbox"/> When applying for the seminar Woundtherapist ICW®/Woundcare specialist ICW®: Proof of participation in the corresponding trainer seminar attached <input type="checkbox"/> Registered in the lecturers list	

To be filled in by the deputy professional management:

<input type="checkbox"/> 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:	
<input type="checkbox"/> Qualifications listed in the lecturers list <input type="checkbox"/> Certificates attached <input type="checkbox"/> Certificates available at the certification body	

Deputy chairperson of the examination committee	
Surname:	
First name:	
<input type="checkbox"/> Qualifications listed in the lecturers list <input type="checkbox"/> Certificates attached <input type="checkbox"/> Certificates available at the certification body	

Lecturer	
Surname:	
First name:	
<input type="checkbox"/> Qualifications listed in the lecturers list <input type="checkbox"/> Certificates attached <input type="checkbox"/> Certificates available at the certification body	

Deputy lecturer	
Surname:	
First name:	
<input type="checkbox"/> Qualifications listed in the lecturers list <input type="checkbox"/> Certificates attached <input type="checkbox"/> Certificates available at the certification body	

Other

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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	