**Ministry of Health (Health Workforce Directorate) Residency Exception Policy**

**Provider Name & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Training Programme: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Trainee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Registration No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insufficient New Zealand citizen/permanent resident candidates**

Please provide detail/evidence for the insufficient number of New Zealand citizens/permanent residents in the above training programme.

**Area of Need**

Please provide details on the how the training programme meets area of need.

**Residency Intentions**

Please provide detail/evidence of residency intentions and of their commitment to remain in New Zealand long term.

**Any other relevant details**

Please provide any other details in support of this trainee, for our consideration when reviewing this exception application

**Provider Details**

**Name:**

**Position:**

**Date:**

**Signature:**

*Please email the completed form to info@healthworkforce.govt.nz*