**ANNUAL REVIEW OF LESS THAN FULL TIME (LTFT) TRAINING**

***Section 1***

***Feedback from trainee***

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| **NAME** |  | |
| **CONTACT ADDRESS** |  | |
| **GMC NUMBER** |  | |
| **CONTACT NUMBER** |  | |
| **EMAIL ADDRESS** |  | |
| **SPECIALTY**  **(include 2nd specialty if applicable)** |  | |
| **TRAINING PROGRAMME** |  | |
| **NATIONAL TRAINING NUMBER OR DEANERY ID NUMBER** |  | |
| **GRADE: FY/CT/ST** |  | |
| **YEAR OF CURRENT PROGRAMME** |  | |
| **Have your circumstances changed since your last review (ARCP).** | **Please provide details:** | |
| **Current % LTFT Working** |  | |
| **Current % OOH working** |  | |
| **Reasons for application**: | If your reason is responsibility for caring for children, please confirm the current ages of your children:  If your reason is responsibility for caring for ill/disabled relative or other dependent, provide a brief update :  If your reason is disability or ill health, provide brief information on your current health status, along with your most recent Occupational Health report:  If your reason is unique opportunities, religious commitment, non-medical professional development or other well founded reasons, please provide a brief update: | |
| **Do you wish to change your number of sessions e.g. either increase or decrease?**  **If Yes, please complete Form D. If moving Health Board then Form A must be completed.** |  | |
| **TRAINEE SIGNATURE** |  | **DATE** |

***Section 2***

***To Associate Dean (LTFT Training)***

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| **CURRENT ARRANGEMENT TO CONTINUE** | **YES** | **NO** |
| **IF NO PLEASE PROVIDE FURTHER INFORMATION** |  | |
| **TRAINEE TO BE SEEN** | **YES** | **NO** |
| **IF YES**  **DATE OF MEETING** |  | |
| **ASSOCIATE DEAN’S**  **SIGNATURE** |  | **DATE** |