# FORM A NHS EDUCATION FOR SCOTLAND

**APPLICATION FOR LESS THAN FULL TIME (LTFT) TRAINING**

***Applications should be made a minimum of 3 months in advance of planned LTFT training start date***

**Please complete and bring one copy to your initial appointment with the local Associate Dean for Flexible Training**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME** |  |  | |  | | |
| **GMC NUMBER** |  |  | |  | | |
| **CONTACT ADDRESS** |  |  | |  | | |
| **CONTACT NUMBER** |  |  | |  | | |
| **EMAIL ADDRESS** |  |  | |  | | |
| **Are you a Tier 2 or Tier 4 Visa Holder?** | **Yes (if yes, please state which visa you hold)** |  | | **No** | | |
| **NAME OF TRAINING PROGRAMME** |  |  | |  | | |
| **NATIONAL TRAINING NUMBER OR DEANERY REFERENCE NUMBER** |  |  | |  | | |
| **GRADE: FY/CT/ST** |  |  | **YEAR OF CURRENT**  **PROGRAMME** |  | | |
| **CURRENT CCT DATE**  **(if applicable)** |  |  | |  | | |
| **Current Place of Work** | **Hospital/Practice:**  **From: To:** | | | | | |
| **Future placement** | **Hospital/Practice:**  **From: To:** | | | | | |
| **CURRENT SPECIALTY**  **(include 2nd specialty if applicable)** |  |  | |  | | |
| **REASON FOR APPLICATION**  **(refer to LTFT guidance document)** |  |  | |  | | |
| **If you are a GP trainee do you still have hospital placements to complete?** | **If yes, please provide number of wte months remaining.** |  | |  | **No** |  |
| **NUMBER OF SESSIONS REQUESTED (%)** |  |  | |  | | |
| **INTENDED START DATE FOR LTFT TRAINING**  **(taking account of accrued annual leave)** |  |  | |  | | |

**FORM A (contd) NHS EDUCATION FOR SCOTLAND**

**Applicant Declaration – please ensure all boxes below are completed**

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| --- | --- | --- | --- | --- | --- |
| **Provide an example of your preferred days/sessions** | |  |  |  | |
| **TRAINING PROGRAMME DIRECTOR NAME** | |  |  |  | |
|  | **I have read the NES Policy on Less Than Full Time Training (LTFT)** <http://www.scotlanddeanery.nhs.scot/trainee-information/less-than-full-time-training-ltft/> | | | | | |
|  | **I understand that this application is the first step of a process including training, service and financial approvals.** | | | | | |
|  | **I understand that the proposed dates, days of work and locations of working are provisional until there is agreement from the relevant Board or GP practice .** | | | | | |
|  | **In accordance with the programme, I understand that I will normally be expected to move between placements and rotations on the same basis as a full-time trainee in the same programme.** | | | | | |
|  | **I understand personal information is recorded on NES data information systems and shared with those who hav responsibility for the organisation, management and delivery of training to help that achieve their function in the planning and delivery of training.** | | | | | |
|  | **I understand I am not permitted to engage in any other paid employment whilst undertaking LTFT, including planned locum wor.k** | | | | | |
|  | **I understand that, if accepted for LTFT, I must submit a renewal application for service each time I rotate to a new placement/specialty in a Board or Practice, of if I change the percentage I am working or if I take time out programme for training, experience, research, maternity leave etc then I will submit a Form D.** | | | | | |
|  | **I understand that the agreement for working LTFT will be reviewed annually.** | | | | | |
|  | **I understand that I cannot commence LTFT training without gaining all required approvals.** | | | | | |
|  | **I understand that I will submit evidence on an annual basis to meet the terms with the ARCP process.** | | | | | |
|  | **I agree that the information given in this application is accurate to the best of my knowledge.** | | | | | |
| **TRAINING PROGRAMME DIRECTOR’S SIGNATURE**  **This is confirmation of your support for training**  **I confirm that I have agreed to a LTFT timetable with this trainee and agree that their required educational needs and curriculum requirements will be met.** | | **(Discussion with TPD before submitting is not mandatory – please complete if relevant)** | | | **DATE** |
| **APPLICANTS SIGNATURE**  **Please complete declaration before signing this form** | |  | | | **DATE** |

**For Deanery Use:**

|  |  |
| --- | --- |
| **Date of initial meeting with Associate Dean** |  |
| **Category 1 or 2** |  |
| **Source of funding** |  |