

# FORM A/B

**APPLICATION FOR LESS THAN FULL TIME (LTFT) TRAINING & SERVICE APPROVAL**

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

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| **Name** |  |
| **GMC Number**  |  |
| **Contact Address**  |  |
| **Contact Number**  |  |
| **E-mail Address**  |  |
|  **Do you hold a Student or Skilled Worker Visa?** | **Yes** [ ]  **No** [ ]   |
| **Training Programme**  |  |
| **Training Programme Director** |  |
| **National Training Number (NTN) or Deanery Reference Number (DRN)** |  |
| **Grade: FY/CT/ST****& Year of Training** |  |
| **Current CCT Date****(if applicable)**  |  |
| **Current Placement****(Please specify if on leave or OOP at present)** | **Hospital / Practice:****From:** **To:**  |
| **Future Placement****(For initial LTFT Application)** | **Hospital / Practice:****From:** **To:**  |
| **Current Specialty****(include 2nd specialty if applicable)**  |  |
| **Reason for Application****(refer to LTFT guidance document)**  |  |
| **Number of Sessions Requested (%)**  |  | **On-call Sessions Requested (%)***(on-call sessions are negotiated directly with the Service but useful information to include to initiate discussions)* |
| **Intended Start Date for LTFT *DD/MM/YYYY****(taking account of accrued annual leave)*  |  |
| **Is your application for the duration of Training Programme or Fixed Period?*****(if Fixed Period please specify proposed start and end dates)*** | **Duration of Training** [ ] **Fixed Period** [ ] **Dates:****From:** **To:**  |
| **Provide an example of your preferred days/sessions which will help with local service discussions*****(Prior to any rotation, please contact your Placement Board / Practice to discuss arrangements)*** |  |
| **Declarations*****Please ensure these are completed prior to submission of the Form A*** |
|  | **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 Placement 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 have responsibility for the organisation, management and delivery of training to help that achieve their function in the planning and delivery of training.** |
|  | **I understand that, if accepted for LTFT, and have requested this for the duration of current Training Programme. If I wish to increase or decrease sessions, I will require to submit a Form D with adequate notice.** |
|  | **I understand that the agreement for working LTFT will be reviewed annually.**  |
|  | **I understand that I cannot commence LTFT training without having without Deanery and service support.** |
|  | **I understand that I will submit evidence on an annual basis to meet the terms with the ARCP process.** |
|  | **I understand that the agreement for working LTFT may be subject to annual review, and if I am due to rotate to another Placement or Health Board, and the prospective service is not able to accommodate my current sessions, then I will be contacted by the Deanery to discuss my options.** |
|  | **I agree that the information given in this application is accurate to the best of my knowledge.**  |
| **Applicant’s Signature*****(Discussion with your TPD is mandatory)*** |  | **DATE**  |
| **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. |  | **DATE**  |
| **Confirmation of Support by Service** | *(Please state signatory full name and designation)* | **DATE** |
| **If not supported, please provide written reason** |  |  |