

**LTFT TRAINING PROGRAMME FORM**

**Contact Details** - Please complete in Block Capitals

<b>Full Name of applicant:</b>	
<b>Address:</b>	
<b>E-mail:</b>	<b>Telephone:</b>
<b>Specialty:</b>	

**MUST BE COMPLETED AND AGREED WITH YOUR EDUCATIONAL SUPERVISOR**

It is strongly recommended that guidance provided by the appropriate College or Faculty is studied to ensure that educational requirements can be met within the proposed duties of the post. If necessary, the advice of the appropriate regional advisor to the College or Faculty could be sought beforehand. A new LTFT Training Programme form MUST be completed each time you move post.

**Consultant(s)/GP Trainer responsible for training:**

**PROPOSED LTFT TRAINING POST**

**Specialty:**

**Hospital/GP Placement:**

**Details of proposed weekly timetable. You should complete this table stating hours to be worked OR fill in specialty specific rota form (if applicable), attach to these forms and agree with Educational Supervisor.**

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
AM					
PM					

**Complete the following:**

Total number of working hours of **full-timers** per week, ie standard plus On Call:   
 NB if a non-resident On Call rota , it is NOT ALL of the On Call hours but only THOSE WORKED which count. **NB standard hours for full-timers are 40 hours per week**

Your % of full time:  Your number of standard hours per week:

Your average number of worked On Call hours per week

Your average number of actual working hours per week (total):

What is your anticipated basic Pay Banding (F5 F6 F7 F8 F9)?

What is the frequency of the Full-timers On Call?

What is the frequency of your On Call?

What is your anticipated banding for the post (FA FB FC)?

Date of commencement in this post:

Please indicate which of the following applies:

Slot Share

Slot Share Partner

Reduced hours in full-time post

Supernumerary Post

**In signing this Programme I am confirming that I have met with and support the above named doctor, and discussed and agreed the proposed weekly timetable:**

**Signed:**

**Date:**

**Educational Supervisor:**

(Please print name)

**In signing this Programme I am confirming that this proposed LTFT training post is suitable for Specialty Training and has approval.**

**Signed:**

**Date:**

**Head of School / Training Programme Director:**

(Please print name)

**SIGNATURE OF LTFT TRAINEE**

**Signed:**

**Date:**

**In signing this Programme you are confirming that you have met with your Educational Supervisor and agreed to your proposed weekly timetable. You are also bound by the eligibility guidelines for LTFT training and must inform us of any changes to your personal circumstances that may affect your eligibility criteria.**

**You will also inform the Postgraduate Deans Office of any changes to the said timetable, rotations, maternity leave etc. A new form MUST be completed if any changes take place.**