Application to 'Act Up' to Consultant Level

Blank forms are available on the NIMDTA website www.nimdta.gov.uk.

Applications **MUST** be **typed** and reach the relevant Hospital Specialty Training team **a minimum of four weeks** prior to the proposed start date.

PART A – Completed by the Trainee			
Name:		***CCT Date:**	
Date last ARCP		**Current ARCP Outcome**	
Specialty:		**NTN:**	
Address:			
Town/City:		**Postcode:**	
Current Local Education Provider (LEP) & Hospital posting:			
Name of Consultant for whom cover is required:			
Name of Supervising Consultant to Trainee:			
DATES OF COVER – period of cover **MUST** not exceed three months WTE and can be pro-rata for trainees who are less than full time. Acting up must be completed prior to CCT.			
From:		**To**:	
Declaration: I confirm that I have discussed this application with my current Educational Supervisor and that they support this proposed period of Acting Up as a Consultant. **SIGNED:** _____ **DATED:** _____			

*All applicants **MUST** be within one year of anticipated CCT date (or last year of training for LTFT trainees).

PART B – Completed by the Clinical Director and Named Consultant Supervisor	
Named Educational Supervisor for duration of Acting Up period	
Daytime Supervision arrangements: **Night time Supervision arrangements:**	

Confirmation of Clinical Director:

I confirm that I support this application for a period of 'Acting Up' as Consultant and confirm that the Supervisor named will provide appropriate supervision. I also confirm that this trainee will have access to consultant supervision for day time and out of hour working during this time period.

CD SIGNATURE: _____ CD NAME (PRINT): _____

DATED: _____

Confirmation of Supervising Consultant: I confirm that I support this application for a period of 'Acting Up' as Consultant and confirm that I will provide appropriate supervision for the duration of this period.

SUPERVISOR SIGNATURE: _____ SUPERVISOR NAME (PRINT): _____

DATED: _____

PART C – Completed by the Head / Deputy Head of School or Training Programme Director

Confirmation of HOS/DHOS/TPD Approval: I confirm that I support this application for a period of 'Acting Up' as Consultant and confirm that the release of the trainee is not anticipated to adversely affect delivery of the programme for other trainees for the period of the request.

SIGNED: _____ DATED: _____

PART D – Completed by the LEP Medical HR Department

Name of HR Contact:			
Trust:			
Designation:		**Telephone Number:**	

Confirmation of Trust Approval: I confirm that Trust funding is available to cover salary costs at __PAs per week plus __% on call, based on the first point of the Consultant Salary Scale (please insert the number of Pas and percentage on-call allowance).

SIGNED: _____ DATED: _____

Approved forms should be returned to specialty.nimdta@hscni.net

PART E – Completed by the Associate Postgraduate Dean
REQUEST APPROVED / NOT APPROVED* (Delete as applicable) **SIGNED: _____ DATED:_____** Last Year of training? ☐ 3 Months duration or less? ☐ Acting up in the same LEP? ☐

Approved form will be emailed to: Trainee, Head/Deputy Head of School, Training Programme Director, Educational Supervisor, Specialty Training Manager, LEP Medical HR Department and Single Lead Employer Trainee Employment Team