**Please complete and submit one copy to your Training Programme Director and one copy to: Associate Postgraduate Dean – Flexible Training, in the appropriate regional office.**

 **FORM D**

**REQUEST TO CHANGE PERCENTAGE/ REVERT TO FULL TIME TRAINING**

**Request should be made 3 months in advance of the date change**

|  |  |
| --- | --- |
| **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 Programme** |
| **CURRENT NO. OF SESSIONS (%)** |  | **No of Sessions requested (%)** |
| **REASON FOR REQUEST** |  |
| **REQUESTED DATE OF CHANGE** |  |
| **CURRENT PLACE OF WORK****(INCL DATES)** | **Hospital / Practice:****From: To:** |
| **FUTURE PLANNED PLACEMENT****(where known)** | **Hospital / Practice:****From: To:** |
| **APPLICANTS SIGNATURE:****(Discussion with your TPD is mandatory)** |  | **Date:** |
| **TRAINING PROGRAMME DIRCTOR’S NAME****TRAINING PROGRAMME DIRECTOR’S SIGNATURE****This is confirmation of your support for training** | **Name:****Signature:** | **Date:** |
| **CONFIRMATION OF SUPPORT BY BUDGET HOLDER** | **Signature of Budget Holder:** | **DATE:** |
| **IF NO, PLEASE GIVE WRITTEN REASON** |  |  |

**Please return to: Associate Postgraduate Dean for Flexible Training, NHS Education for Scotland, at the appropriate regional office**