

**FORM D**

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

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

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| --- | --- | --- | --- | --- |
| **Name** |  | | | |
| **GMC Number** |  | | | |
| **Contact Address** |  | | | |
| **Contact Number** |  | | | |
| **E-mail Address** |  | | | |
| **Do you hold a Student or Skilled Worker Visa?** |  | | | |
| **Training Programme** |  | | | |
| **Training Programme Director** |  | | | |
| **National Training Number (NTN) or Deanery Reference Number (DRN)** |  | | | |
| **Grade: FY/CT/ST**  **& Year of Training** |  | | | |
| **Current Number of Sessions (%)** |  | | | |
| **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)* | |
| **Reason for Request** |  | | | |
| **Requested Date of Change**  **DD/MM/YYYY**  ***(taking account of accrued annual leave)*** |  | | | |
| **Is this for the duration of remainder of current Training Programmer or Fixed Period?**  ***(If fixed time period please specify dates)*** |  | | | |
| **If for fixed time period, do you wish to revert back to current sessions after this period?** |  | | | |
| **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)*** |  | | | |
| **Current Placement**  **(Please specify if on leave or OOP at present)** | | **Hospital / Practice:**  **From: To:** | | |
| **Future Placement for start of LTFT** | | **Hospital / Practice:**  **From: To:** | | |
| **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 Service**  ***(at time of change of % request)*** | | **Signature of Service:**  ***(e.g. Clinical Director or Practice Manager)*** | | **Date:** |
| **If no, please provide written reason** | |  | |  |

**Please send completed Form D to your Deanery Programme Administrator:**

[*https://www.scotlanddeanery.nhs.scot/about-us/our-people/training-management-team/*](https://www.scotlanddeanery.nhs.scot/about-us/our-people/training-management-team/)