

**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***

|  |  |
| --- | --- |
| **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/)