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| --- | --- |
| Educator Study Leave Application |  |

# Personal Details

|  |  |  |  |
| --- | --- | --- | --- |
| NES Role |  | Specialty/ Specialty grouping applicable to NES role |  |
|  |
| Name |  | Email address |  |
| GMC Number |  | Postal address |  |

|  |  |  |
| --- | --- | --- |
| Study Leave Details |  |  |
| Details of study leave activity | Click or tap here to enter text. |  |
| How does the study leave request relate to your educator role? | Click or tap here to enter text. |  |
| Provider of S/L activity | Click or tap here to enter text. |  |
|  |  |  |
| Start date | Click or tap to enter a date. |  |
|  |  |  |
| End date | Click or tap to enter a date. |  |
|  |  |  |
| No. days requested | Click or tap here to enter text. |  |
|  |  |  |
| Location of activity | Click or tap here to enter text. |  |
| Is there a reason for attending this course with the specified provider or on the specific date? | Click or tap here to enter text. |  |
| Confirmation of NHS Board/ Service approval of S/L | **Yes** |  |
|  |  |
| **Anticipated Expenses**: |
|  |  |
| Course/ attendance fee | Click or tap here to enter text. |
|  |  |
| Travel costs | 0 |
|  |  |
| Accommodation costs | 0 |
|  |  |
| Subsistence costs | 0 |
|  |  |

### Declaration

1. I have sought permission to be away from the clinical area and have completed and submitted the appropriate local forms.
2. I shall ensure that my colleagues are fully aware of my absence and that my clinical responsibilities will be covered.
3. I have read the educator study leave policy & operational guide.
4. I have provided all the information required for the application to be considered in full.
5. I shall submit all relevant receipts within 3 months of the date of the study leave event if this application is approved with expenses.
6. I shall inform the Deanery of any subsequent changes to this application that may result in refundable expenditure.

|  |  |  |
| --- | --- | --- |
| Signature |  |  |
|  | Signature of the Person Submitting this Form |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Signature |  |  |  |  |  |
|  | MM |  | DD |  | YY |

Please return form to [nes.emdoffice@nhs.scot](mailto:nes.emdoffice@nhs.scot)

**INTERNAL USE ONLY**

# Authoriser Details

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | NES Role |  |
|  |
| Decision | Choose an item. | If the request is declined please provide a short explanation of why. |  |
| Expenses (please specify if authorizing a set a amount or payment in full) |  | Date | Click or tap to enter a date. |