**South West Fellowship Application Form**

Please complete this form in its entirety. If you are submitting any additional sheets please indicate on the top of each sheet your name, GMC number and training programme.

**Please note:** **Only section 3 is provided to the shortlisting and interviewing panels.**

|  |
| --- |
| **Section 1 – Personal details** |
|  |
| **Applicant surname:** |       |
| **Applicant forenames:** |       |
| **GMC Number** |       | **NTN / DRN Number:***(where applicable)* |       |
| **Email address:** |       |
| **Mobile number:** |       |
| **Postal address:***(including postcode)* |       |
|  |
|  |
| **Section 2 – Training details**  |
|  |
| **Current training programme** |       |
| **Current training grade** |       |
| **Current training year:** |       |
| **Current training post:** |       |
| **Current employer:** |       |
| **Date and outcome of last ARCP:** |       |
| **Anticipated CCT date:** |      /     /      |
| **Do you anticipate remaining in the same Trust for the duration of the Fellowship?**  |       |

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|  |
| **Section 3 – Applicant submission** |
|  |
| **Reason for wanting to undertake this support secondment?** (<250) |
|       |
| **Why do you believe you would be suitable for this support secondment?** (<250) |
|       |

|  |
| --- |
| **Section 4 – Reference** |
| I, as the Training Programme Director for this trainee, support this application and confirm that:            (name of Postgraduate Doctor in Training) is a suitable candidate: |
| **Full Name:** |       |
| **Employer** |       |
| **GP Practice (if required)** |       |
| **Contact email address:** |       |
| **Signature and Date:** |            /     /      |
| I, the Postgraduate Doctor in Training, confirm that:* the information provided via this application is true and accurate;
* I can provide evidence and additional documentation if required by NHSE Southwest;
* I have read and understood the terms and conditions of the secondment
 |
| **Full Name:** **(block capitals)** |       |
| **Trainee signature:** |       |
| **Date signed:** |      /     /      |

*Please return your completed application form by* ***17:00*** *on the closing date to:*

**england.psedinfo.sw@nhs.net**

**Please complete the monitoring information on the next page.**

**INTERVIEW DATE:**

|  |  |
| --- | --- |
| **DATE:** | Monday 26th February 2024. **TBC**  |
| **VENUE:** | Virtual via MS Teams |

**Monitoring Information**

NHS Organisations recognise and actively promote the benefits of a diverse workforce. We are committed to maintain a working environment that is free from discrimination and one that promotes equality & diversity in its policies, procedures and practices.

Completion of the following questions is **voluntary** and for monitoring purposes only. Any information that you do provide will be treated in the strictest confidence.

**Please identify the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Gender:** |  | **Prefer not to say:**  |  |
| **Age:** |  | **Prefer not to say:**  |  |
| **Marital Status:** |  | **Prefer not to say:**  |  |
| **Sexual orientation:** |  | **Prefer not to say:** |  |

**Please identify your religion or belief:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Atheism  |  | Buddhism |  | Christianity  |  | Hinduism |  |
| Islam  |  | Judaism |  | Sikhism |  | Prefer not to say  |  |
| Other (please specify)  |  |

**Please identify your ethnic origin:**

|  |  |  |
| --- | --- | --- |
| **Asian or Asian British** | Bangladeshi |  |
| Indian  |  |
| Pakistani  |  |
| Other Asian Background |  |
| **Black or Black British** | African |  |
| Caribbean |  |
| Other Black Background |  |
| **Chinese or Chinese British** | Chinese |  |
| Other Chinese Background |  |
| **Mixed** | White & Black African |  |
| White & Black Caribbean |  |
| White & Asian |  |
| Other Mixed Background |  |
| **White** | White-British  |  |
| White-English  |  |
| White-Irish  |  |
| White-Scottish |  |
| White-Welsh |  |
| White-European |  |
| White Non-European |  |
| Other White background |  |
| **Other** |  |  |
| *Please state:* |
| **Prefer not to say** |  |  |

**Do you consider yourself to have a disability according to the terms given in the Disability Discrimination Act?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes |  | No |  | Prefer not to say |  |

If you have answered yes, please indicate the type of impairment which applies to you. If your experience more than one type of impairment, please tick all the types that apply. If your disability does not fit any of these types, please mark Other and specify.

|  |  |
| --- | --- |
| Physical/mobility impairment |  |
| Visual impairment |  |
| Hearing impairment |  |
| Mental health condition |  |
| Learning disability/difficulty |  |
| Long-standing illness or health condition |  |
| Other (Please specify) |  |