**Confirmation of Funding for Consultant Applications**

**Consultant applications will only be considered by CAAC on receipt of this form approved by the AHD**

This form should be fully completed and submitted to the Acute Hospital Division Pay Bill Group Email acutehospitals@hse.ie

The form will be reviewed by the Acute Hospitals Division and returned to the Hospital Group Office confirming:

1) Approval of funding source ***or***

2) Request for further information

Once completed by the Acute Hospital Division this form should be attached to all Consultant applications being submitted to the Consultants Division, NDTP for consideration by the Consultant Applications Advisory Committee. Consultant Applications cannot be submitted without this confirmation of funding form signed by Acute Hospitals Division attached to the application, with immediate effect.

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| Name of Hospital Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Principal Clinical Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other clinical site(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  New or Replacement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If replacement, Is there a locum in place?: Yes \_\_\_\_\_ No \_\_\_\_\_\_\_: ***If Yes****, provide name and date commenced*  Date locum commenced \_\_\_\_\_\_\_\_\_\_\_\_ Name of Locum\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Funding Source for this post: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please provide specific details for the post and associated costs:  *If agency conversion or other/outside funding, provide backup documentation/information, i.e. current agency run rate etc*  *If development letter is not available, CFO, Hospital Group, signature is required*.   |  | | --- | |  |   Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital General Manager/CEO  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital Group CEO (Or Delegated Officer) |

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| ***For completion by Acute Hospitals Division:*** | |
| Date Received: | |
| Funding details reviewed :  Date | |
| Approved : | AHD Decision No: |
| Date: | |