##### Appendix A:

**Stage 1: Expression of Interest for HSE National Supernumerary Flexible Training Scheme**

*Note: All forms must be completed by typing in the responses and signing the form. Hand-written applications will not be accepted.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Section A – Personal Details** | | | |
|  | | | |
| **1** | First Name: |  |  |
|  |  |  |  |
| **2** | Last Name: |  |  |
|  |  |  |  |
| **3** | Postal Address: |  |  |
|  |  |  |  |
| **4** | E-mail Address (mandatory) |  |  |
|  |  |  |  |
| **5** | Home Telephone Number (optional): |  |  |
|  |  |  |  |
| **6** | Mobile Telephone Number (mandatory): |  |  |
|  |  |  |  |
| **7** | Work Telephone Number (optional) |  |  |
|  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| For HSE Use only: |  | |
| HSE Date of Receipt | HSE Ref: |  |
| Reviewed: |  |
| Date: |  |
| Signed: |  |
| NDTP official: |  |
|  | Status: |  |

*NFTP Stage 1 Application Page 2*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section B – Medical Council Registration** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  | | |  | | | | |  | | | | | | | | | | | | | | |
| **8** | Name in which you are registered with the Medical Council (of Ireland) | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | |  | | | | | |
| **9** | Medical Council registration number | | |  | |  | | | | |  | | | |  | | |  | | | | |  | | | |
|  |  | | |  | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | |  | | | | | |
| **10** | Please indicate (with an “**X**” in the appropriate box) the division of the Medical Council (of Ireland)’s register you are currently registered | | | (i) Trainee Specialist Division | | | | | | | | | | | | | | | | |  | | | | | |
|  | (ii) General Division | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | | (iii) Supervised Division | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | | (iv) Specialist Division | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | | (v) Not registered | | | | | | | | | | | | | | | | |  | | | | | |
|  |  | | |  | | |  | | | | |  | | | | | | | | | | | | | | |
| **Section C – Details of Training Programme** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **11** | | Name of Training Body enrolled with: |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | |  | | | | |  | | | | | | | | | | | | |
| **12** | | Name of Training Programme: |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **13** | | Date of entry onto Programme: (DD-MM-YYYY) |  | |  | | | | ▬ |  | | | |  | | ▬ |  | |  | | |  | |  |
|  | |  |  | | | | |  | | | | |  | | | | | | | | | | | | |
| **14** | | Current Year of Training: |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | | | | |
| **15** | | Year of Training from July 2021: |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | | | | |
| **16** | | Number of expected years of training remaining (on a full-time basis) prior to award of CSCST: |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | | | | |
| **17** | | Name of National Specialty Director (/Dean of Training Programme) |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | | | | |
| **18** | | Details of periods of leave taken on the scheme to-date (outside of normal annual and study leave undertaken)   |  |  |  |  | | --- | --- | --- | --- | | Start date | End date | Time in weeks | Reason  (sick, maternity, other) | |  |  |  |  | |  |  |  |  |   Have all assessments been satisfactorily completed to date: | Yes  No  If No please provide details | | | | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | | | | |

*NFTP Stage 1 Application Page 3*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section D – Previous Flexible Training** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **19** | Are you currently in a flexible training post? | Yes | | |  | | | |  | | | | | | | | | | | |
|  |  | No | | |  | | | |  | | | | | | | | | | | |
|  |  |  | | |  | | | |  | | | | | | | | | | | |
| **20** | Have you previously been in a flexible training post? | Yes | | |  | | | |
|  |  | No | | |  | | | |
|  |  | |  | | | | | | | | | | | | | | | |  |
| **21** | If you answered “yes” to either of the above questions, please state the start date and end date of the post, or most recent post if more than one: (DD-MM-YYYY) |  | |  | | |  |  | | |  |  |  |  | |  |  |
|  |  | |  | | |  |  | | |  |  |  |  | |  |  |
|  | Start date: |  | |  | | | ▬ |  | | |  | ▬ |  |  | |  |  |
|  |  |  | |  | | |  |  | | |  |  |  |  | |  |  |
|  | End Date: |  | |  | | | ▬ |  | | |  | ▬ |  |  | |  |  |
|  |  |  | | | |  | | | |  | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section E – Reason for Application to National Flexible Training Scheme** | | | | |
|  | | | |
| **22** | Please outline below your reasons for seeking a position on the National Flexible Training. You may attach additional sheets, medical certs or other documentation as required. Please note that all information provided in this section will be treated as confidential by NDTP. | | | | |
|  |  | | | | |
|  |  |  |  | | |

*NFTP Stage 1 Application Page 4*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section F – Proposed Structure of Flexible Training** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  |  |  |  | |  |  | |  |  |  |  | |  |  |
| **23** | Proposed start date for flexible training: |  |  | | ▬ |  | |  | ▬ |  |  | |  |  |
|  |  |  |  | |  |  | |  |  |  |  | |  |  |
| **24** | Proposed end date for flexible training: |  |  | | ▬ |  | |  | ▬ |  |  | |  |  |
|  |  |  |  | |  |  | |  |  |  |  | |  |  |
| **25** | Proposed % work commitment: |  | | | | | | | | | | | | |
|  |  |  | | | | | | | | | | | | |
| **26** | Proposed clinical practice working pattern (e.g. 2 days on/3 days off; one week on/one week off; 2.5/2.5 per week; 5 mornings a week etc.) |  | | | | | | | | | | | | |
|  | *Note: working pattern must be over a reference period of 2 weeks i.e. at least 50%. of every 2-week period must be worked* |
|  |  |  | |  | | |  | | | | | | | | |
| **27** | Details of the Post due to commence in July 2020 i.e. Specialty / Sub Specialty plus Location (if known) |  | |  | | |  | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section G – Declarations** | | | | | | | | | | | | | | | | | | | | | | |
| * I have discussed my reason for seeking part-time training with my training scheme prior to applying. * I agree to adhere to the minimum hours per week including education release time and out of hours commitment as required by the training body * I have informed my future training post of my decision to train part-time * I understand that I will not be able to accelerate my training * All assessments have been satisfactorily completed to date | | | | | | | | | | | | | | | | |
| **Section H – Signature** | | | | | | | | | | | | | | | | | | | | | | |
| **28** | Signature of Applicant: |  | | | | | | | | | | | | | | | | | | | |
|  |  |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  |
| **29** | Printed name of Applicant: |  | | | | | | | | | | | | | | | | | | | |
|  |  |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  |
| **30** | Date (DD-MM-YYYY): |  |  | | ▬ | |  | |  | | ▬ | |  | |  | | |  | |  | |

**Please ensure all declarations have been reviewed and ticked if appropriate.**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Submission of completed form:**

Please return the completed application form by 30th October 2020:

1. by e-mail to [Thomas.hynes1@hse.ie](mailto:Thomas.hynes1@hse.ie)

OR

1. Original signed copy by post to Mr Thomas Hynes, HSE National Flexible Training Scheme Administrator, National Doctors Training & Planning, Block 9E, Sancton Wood Building, Heuston South Quarter, St John’s Road West, Dublin 8.

Queries to: Ellen O’Doherty

E: [Ellen.odoherty@hse.ie](mailto:Ellen.odoherty@hse.ie)

T: 01 695 9919