**CONFIDENTIAL**

**APPLICATION FOR ENROLMENT IN THE PUBLIC HEALTH TRAINING PROGRAMME**

**PLEASE COMPLETE THE FORM IN BLOCK CAPITAL LETTERS**

|  |
| --- |
| **Please complete and return the signed form along with your CV to** [**educ@fph.org.uk**](mailto:educ@fph.org.uk) **within 3 months of starting the Training Programme. Please ensure that both Sections are completed. Details for payment of first annual fee is provided on page 6.** |

**SECTION 1: TO BE COMPLETED BY SPECIALTY REGISTRAR**

**1. Contact information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME** |  | **FIRST NAMES** |  |
| **FORMER NAME** |  | **PREFERRED TITLE** |  |
| **DATE OF BIRTH** |  | **GENDER** | **M**  **F** |
| **CORRESPONDENCE ADDRESS** | | | |
| TOWN / CITY: POSTCODE: | | | |
| **EMAIL** |  | | |
| **TELEPHONE** |  | | |
| *NOTE: Please notify FPH immediately of any changes to your contact details* | | | |

**2**. **Education and professional qualifications**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PRIMARY QUALIFICATION or DEGREE** | | | | | |
| **NAME OF THE QUALIFICATION** | **DATES ATTENDED** | | **DATE AWARDED** | | **NAME & COUNTRY OF AWARDING INSTITUTION** |
|  |  | |  | |  |
| **ACADEMIC QUALIFICATIONS IN PUBLIC HEALTH** | | | | | |
| **NAME OF THE QUALIFICATION /COURSE** | **DATES ATTENDED** | | **DATE AWARDED** | | **NAME & COUNTRY OF AWARDING INSTITUTION** |
|  |  | |  | |  |
| **QUALIFICATIONS IN PUBLIC HEALTH** | | | | | |
| **PART A MFPH**  **PART B MFPH** | | Y N  Y N | | **DATE PASSED** | |
| **OTHER HIGHER / RELEVANT QUALIFICATIONS** | | | | | |
| **NAME OF THE QUALIFICATION** | **DATES ATTENDED** | | **DATE AWARDED** | | **NAME & COUNTRY OF AWARDING INSTITUTION** |
|  |  | |  | |  |

**3. Public Health training programme**

|  |  |
| --- | --- |
| **GRADE APPOINTED AT:** | **ST1** **ST2 ST3 ST4 ST5** |
| **TRAINING PROGRAMME NUMBER**  **(NTN):** |  |
| **PLACEMENT** |  |
| **DEANERY/REGION** |  |
| **WTE**  **If part time, express as a percent of full time below:** | **FULL TIME**    **PART TIME**  \_\_\_\_ % |
| **START DATE ON SCHEME:** |  |

**4. Previous posts /experience**

Please submit a copy of your CV with your Enrolment Form

**For Registrars seeking registration with General Medical Council (GMC)**

|  |  |  |  |
| --- | --- | --- | --- |
| **GMC REGISTRATION TYPE:** | | **FULL** Y N | |
| **GMC NUMBER:** |  | **DATE GRANTED:** |  |

At the time of appointment, this group is expected to be eligible for full registration with , and hold a current license to practice from, the GMC at intended start date and have a minimum of 2 years of postgraduate medical experience by time of appointment (equivalent to that obtained in a UK Foundation Training Programme); have evidence of either current employment in a UKFPO- affiliated foundation programme or 12 months experience after full GMC registration, and evidence of achievement of foundation competences in the three years preceding the intended start date from a UKFPO- affiliated foundation programme or equivalent, in line with GMC standards/ Good medical Practice.

Please specify the relevant Foundation posts (or equivalent) below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **POST (INCLUDING GRADE)** | **ORGANISATION** | **DATES** | | **FT / PT (PLEASE INDICATE WTE)** |
| **From** | **To** |
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Please submit copies of the following documentation as evidence of achievement of Foundation Competencies:

* Foundation Achievement of Competence Document (FACD)

or

* Alternative Certificate confirming achievement of foundation competencies

**For Registrars seeking registration with the UK Public Health Register**

At the time of appointment, this group is expected to have undertaken at least 60 months

whole time equivalent (WTE) work experience, of which at least 24 months (WTE) must be

in an area relevant to population health practice. The 24 months should be at Band 6 or

above of Agenda for Change or equivalent and minimum of 3 months (WTE) at Band 6 level

or equivalent in the 3 years preceding the intended start date.

Please specify the posts for 60 months general experience and 24 month A&C 6 experience

below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **POST (INCLUDING ORGANISATION)** | **DATES** | | **FT / PT (PLEASE INDICATE WTE)** | **MONTHS (WTE) COUNTED TOWARDS GENERAL EXPERIENCE** | **MONTHS (WTE) COUNTED TOWARDS PH EXPERIENCE** |
| **From** | **To** |
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| **TOTAL** | | | |  |  |

**5. DECLARATION**

I declare that the information I have given in support of my application is, to the best of my knowledge and belief, true and complete. I understand that if subsequently it is discovered that any statement is false or misleading or that I have withheld relevant information, my application will be disqualified.

|  |  |
| --- | --- |
| **SIGNATURE** |  |
| **PRINT NAME** |  |
| **DATE** |  |

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| Please submit the completed form with your first annual payment £298  **Please note the following payment methods**   * **Cheque:** A sterling cheque drawn on a UK bank made payable to: "Faculty of Public Health". * **Bank Transfer (BACs) to our account:**   Nat West  25 Great Portland Street Branch  London W1A 1GA  Account No.: 36191159  Sort Code: 60-09-15   * **Credit Card/Debit payment:** by telephone (note: if paying by credit card there is an additional charge of 1.61% or 3.35% if using American Express card) |

**SECTION 2: TO BE COMPLETED BY TRAINING PROGRAMME DIRECTORS**

**Please check that the information provided by the applicant, concerning the appointment, is correct. In addition, please give the following details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Has the applicant already completed an academic public health course? If Yes, please provide the following information** | | | | | Y N |
| **Qualification** | **Dates attended** | | **Date awarded** | | **Name & country of awarding institution** |
|  |  | |  | |  |
| **Will the applicant be undertaking an academic public health course/ modules following appointment? If Yes, please provide the following information** | | | | | Y N |
| **Qualification / Modules** | | **Length of the Course** | | **Academic Institution** | |
|  | |  | |  | |
| **Will the applicant be receiving a CCT or CESR (CP) at the end of training?** | | | | | CCT  CESR (CP) |
| **FOR APPLICANTS APPLYING FOR A CESR (CP)** | | | | | |
| **Please confirm the entry point.** | | | **ST3**[ ] **ST4**[ ] **ST5**[ ] | | |
| **Please confirm that you attached information on achieved competencies relevant at that level on a separate sheet (please note the first ARCP is the latest point the competencies gained in pervious posts can be considered)** | | | | | Y N |

**Provisional date for the award of CCT/ CESR (CP)**

|  |  |
| --- | --- |
| **Which Register the StR will be applying for?** | GMC UKPHR |
| **What provisional CCT/ CESR (CP) date have you assigned?** |  |

|  |  |
| --- | --- |
| **TPD SIGNATURE** |  |
| **REGION/DEANERY** |  |
| **DATE** |  |

**SECTION 3: FPH DIRECTOR OF TRAINING COMPLETES THIS SECTION**

1. **Previous experience**

|  |  |
| --- | --- |
| **To confirm registration, has sufficient information been provided for :** | |
| **StRs applying for GMC registration** | Y N NOT APPLICABLE |
| **StRs applying for UKPHR registration** | Y N NOT APPLICABLE |
| **StRs applying through CESR (CP) route** | Y N NOT APPLICABLE |
| **Comments** | |

**2. Authorisation**

**Is this application approved? Y N**

|  |  |
| --- | --- |
| **PROVISIONAL CCT/ CESR (CP) DATE:** |  |
| **SIGNATURE** |  |
| **NAME:** |  |
| **DATE** |  |

Enrolment fee paid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)