**CONFIDENTIAL**

**OUT OF PROGRAMME (OOP) REQUEST FORM**

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

|  |
| --- |
| **Please return the signed form to** [**educ@fph.org.uk**](mailto:educ@fph.org.uk) **3 months before starting the OOP. Form must be submitted by the LETB. The Faculty will not accept applications directly from Registrars.** |

**1. Type of Application:**

|  |  |  |
| --- | --- | --- |
|  | **NEW REQUEST** | **EXTENSION** |
| **OUT OF PROGRAMME TRAINING (OOPT)** |  |  |
| **OUT OF PROGRAMME FOR RESEARCH (OOPR)** |  |  |

**2. Registrar’s Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SURNAME** |  | | **FIRST NAME** |  |
| **NTN NUMBER** |  | | **GMC NUMBER (If Applicable)** |  |
| **EMAIL** |  | | | |
| **ADDRESS** |  | | | |
| **TELEPHONE** |  | | | |
| *NOTE: Please notify FPH immediately of any changes to your contact details* | | | | |
| **CURRENT YEAR OF TRAINING** | | **ST1 ST2 ST3 ST4 ST5** | | |
| **CURRENT CCT DATE** | |  | | |

**3. Placement Details:**

|  |  |
| --- | --- |
| **PROPOSED START DATE OF OOP** |  |
| **PROPOSED END DATE OF OOP** |  |
| **DURATION OF OOP (IN MONTHS)** |  |
| **WHAT WILL BE YOUR PROVISIONAL CCT DATE IF THE APPLICATION IS APPROVED?** |  |

|  |  |  |
| --- | --- | --- |
| **NAME OF THE ORGANISATION** |  | |
| **ADDRESS** | | |
| TOWN / CITY: POSTCODE: | | |
| **IS THIS IS A GMC APPROVED PLACEMENT** | | Y N |

|  |  |  |  |
| --- | --- | --- | --- |
| **PLEASE PROVIDE THE PURPOSE OF OOP / BRIEF DESCRIPTION OF PROJECT/S .** | | | |
|  | | | |
| **LEARNING OUTCOMES (**please provide the list of learning outcomes which will be achieved during this placement. The learning outcomes can be accessed at<https://www.fph.org.uk/media/1751/ph-curriculum-2015_approved.pdf>  Please tick the appropriate box ‘**P**’ or ‘**F**’ to show which Learning Outcomes will be partially achieved or fully achieved. (These should be discussed and approved by your TPD). | | | |
| Number | | Description | **P** | **F** |
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**4. Arrangements for Supervision**

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| --- | --- |
| **NAME OF THE EDUCATIONAL SUPERVISOR** |  |
| **ORGANISATION** |  |
| **NAME OF THE CLINICAL /ACTIVITY SUPERVISOR(S)** (if different from the educational supervisor) |  |
| **ORGANISATION** |  |
| **Additional information on the supervision arrangements can be provided below** | |
|  | |

**5. Signatures**

**REGISTRAR**

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

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

**TRAINING PROGRAMME DIRECTOR**

**Is this application supported? Y N**