**COMPLETION OF TRAINING FORM**

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| **This form MUST be completed for all Specialty Registrars (StRs) completing training.**  **The form must be returned to the Faculty by Health Education England/ Training Programme Director with copies of all ARCP outcome forms.**  **Please note that CCT and ARCP outcome forms might be shared with GMC/ UKPHR (as applicable) to meet the quality assurance requirements.** |

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| |  |  |  |  | | --- | --- | --- | --- | | **SURNAME** |  | **FIRST NAMES** |  | | **NTN NUMBER** |  | | | | **SPECIALIST REGISTER** | StR (medicine) StR (background other than medicine) | | | |  |  |

**Please list dates of all ARCP assessments during the training period**

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| **ASSESSMENT DATES** | **OUTCOME (“satisfactory", etc)** |
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**Academic Period: Please indicate the number of months (WTE) counted towards training while undertaking an academic course in Public Health e.g. MPH.**

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| --- | --- | --- | --- | --- |
| **Course Name** | **Dates** | | **Full Time / Part Time (if part time please indicate wte)** | **Number of months (wte) spent on MPH while in training** |
| From | To |
|  |  |  |  |  |

**Training Placements: Please list placements and training dates, excluding time spent during an academic course in public health, in chronological order to confirm**

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| --- | --- | --- | --- | --- |
| **Placement name and location** | **Dates** | | **FT / PT (if part time please indicate wte)** | **Number of months (wte) counted towards training** |
| **From** | **To** |
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**Please list any out of programme placements not approved for training below**

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| **Placement name and location** | **Reason for OOP** | **Dates** | **WTE** |
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**Please confirm the following**

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| **CCT CRITERIA** | |
| Satisfactorily completion of 48 months of supervised training in posts approved by the GMC or other competent bodies in the EEA after completion of a suitable academic course in public health | Y N  Please indicate the number of months (WTE): |
| At least **3 months** in health protection in a service location within the NHS, (or equivalent in any country of the UK) or DMS | Y N  Please indicate the number of months (WTE): |

**Date for the award of CCT/ CESR (CP)**

|  |  |
| --- | --- |
| **CCT / CESR (CP) DATE** |  |

**Please confirm that the StR has demonstrated all the required competencies to the level expected in Consultant/Generalist Specialist practice; or that all of the learning outcomes have been achieved:**

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| --- | --- |
| **SIGNATURE** |  |
| **NAME** |  |
| **DEANERY/REGION/COUNTRY** |  |
| **DATE** |  |