**CONFIDENTIAL**

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

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| --- |
| **Please complete and return the signed form along with the relevant documentation to** [**educ@fph.org.uk**](mailto:educ@fph.org.uk) **within 3 months of starting the Training Programme. Please ensure that checklist, sections 1 and 2 are completed. Incomplete forms will be returned to you for completion** |

**CHECKLIST**

|  |  |
| --- | --- |
| **Have you completed and signed Section 1?** | **Y N** |
| **Have you attached your CV?** | **Y N** |
| **Has your Training Programme Director completed and signed Section 2?** | **Y N** |
| **For Registrars seeking registration with General Medical Council (GMC), have you attached the relevant documents, as applicable, to demonstrate your eligibility.** Please refer to page 4. | **Y N** |
| **Have you completed and returned the membership admission form?** | **Y N** |
| **Have you paid your first annual subscription?**  **You will have received an invoice for £298 and payment is due now**  **If payment has not been made then please note the following payment methods**   * **Click the payment link within the invoice to make a secure online payment** * **Bank Transfer (BACs) to our account:**   Nat West  25 Great Portland Street Branch  London W1A 1GA  Account No.: 36191159  Sort Code: 60-09-15   * Direct Debit please download complete and return the direct debit mandate to membership@fph.org.uk | **Y N** |

**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. Public Health training programme**

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

**3**. **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** | | | | | |
| **The Faculty of Public Health Diplomate examination (DFPH)/Part A**  **The Faculty of Public Health Final Membership examination (MFPH)/Part B** | | Y N  Y N | | **DATE PASSED** | |
| **OTHER HIGHER / RELEVANT QUALIFICATIONS** | | | | | |
| **NAME OF THE QUALIFICATION** | **DATES ATTENDED** | | **DATE AWARDED** | | **NAME & COUNTRY OF AWARDING INSTITUTION** |
|  |  | |  | |  |

**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 achievement of foundation competences in the three and half years preceding the advertised post for the round of start date for the round of application, via one of the following methods:

* Current employment in a UKFPO-affiliated foundation programme; or
* Having been awarded an FPCC (or FACD 5.2) from a UK affiliated foundation programme within the 3.5 years preceding the advertised post start date; or
* 12 months medical experience after full GMC registration (or equivalent post licensing experience), and evidence to commence specialty training in the form of a Certificate of Readiness to Enter Specialty Training

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

This group is expected to have at least 48 months (wte) work experience by application closing date, 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 a minimum of 3 months (wte) at Band 6 level or equivalent in the three and a half years preceding the intended start date.

Please specify the posts for 48 months work experience including the 24 months at Band 6 or above of Agenda for Change or equivalent 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** |  |

**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 please indicate that sufficient information has 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** |  |