**F2 APPLICATION FOR TASTER SESSIONS**

**Authorised Leave for Taster Sessions is to give F2s the opportunity to gain experience in a specialty they may be interested in pursuing as a career. This leave is not mandatory and will be at the discretion of the department the F2 is working for. Up to 5 taster days can be taken across F1/F2. (These don’t all have to be taken in F1, some could be taken in F2.)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PART A – TASTER SESSIONS LEAVE DETAILS | | | | | | | | | | | | | | | | | | |
| Surname: |  | | | | | | | Forenames | |  | | | | | | | | |
| Present Post: Speciality: | | | | | |  | | Grade | | **F2** | | | | | Bleep No: | | |  |
| Main Hospital: | | | | | | |  | Department | |  | | | | GMC No: | | |  | |
| Post at time of TSL if different from above: | | | | | | | | | | | | | | | | | | |
| **Specialty taster session is being taken in:** | | | | | | | | | | | | | | | | | | |
| **......................................................................................................** | | | | | | | | | | | | | | | | | | |
| **Dates: From: To: No. of days (max 3 days):** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Location: (**where taster session is being taken) ………………………. | | | | | | | | | | | | | | | | | | |
| ***n.b.* My department/ward/supervisor have been advised – *tick box 🡪*** | | | | | | | | | | | **Yes** | | | | | | | |
| **The following colleagues have agreed to cover my duties:** | | | | | | | | | | | | | | | | | | |
| Name (print): | | | |  | | | | Signed: |  | | | | | | | | | |
| Name (print) | | | |  | | | | Signed: |  | | | | | | | | | |
| **Signed (Applicant):** | | | | |  | | | | | | | | Date: | | |  | | |
| PART B – APPROVAL OF ROTA / MEDICAL STAFFING CO-ORDINATOR | | | | | | | | | | | | | | | | | | |
| **\* Approved / Not Approved** *\*delete as appropriate* | | | | | | | | | | | | | | | | | | |
| Name (print): | | | |  | | | | | | | | | | | | | | |
| Signed: | | |  | | | | | | | | | Dated: |  | | | | | |
| Submit to the Medical Education Centre where you are based for consideration ***6 weeks prior*** to the period requested.  Retrospective claims will not be considered.  Leave will not be granted unless supported by a properly agreed education plan. | | | | | | | | | | | | | | | | | | |
| **PART C – APPROVAL BY FOUNDATION TRAINING PROGRAMME DIRECTOR** | | | | | | | | | | | | | | | | | | |
| **\* Approved / Not Approved** *\*delete as appropriate* | | | | | | | | | | | | | | | | | | |
| Signed: | |  | | | | | | | | | | Dated: |  | | | | | |

**Office Use Only:**

Date entered on Database

Date applicant e-mailed with approval