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**Form C: Confirmation of Placement and Work Schedule for Less Than Full Time Trainee**

## To be completed by trainee in consultation with Training Programme Director and/or Clinical/ Educational Supervisor

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| **Name:**  | **Placement Details:** *Please tick appropriate box* |
| Slot share:name of S/Share Partner **(To be confirmed by your TPD)** |  | Supernumerary  | LTFT in F/T slot: |  |
|  |
| **GMC Number:** | **Trust:** |
| **Date Placement Starts:** | **Date Placement Ends:**  |
| **Specialty:** | **Grade:**  |
| **Agreed Percentage:** | **Out of Hours Percentage (this should be pro-rata to the full time OOH contribution):** |

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| ***To be signed by both TPD and CS/ES:*** *In signing this you are approving this post and confirming that this post is within training capacity and does not affect the duties of any other member(s) of staff***Training Programme Director****Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Please print name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Clinical/Educational Supervisor****Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Please print name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **DAY** | **A.M.** | **P.M** |
| Monday  |  |  |
| Tuesday  |  |  |
| Wednesday  |  |  |
| Thursday |  |  |
| Friday |  |  |
| Saturday  |  |  |
| Sunday  |  |  |

I confirm that I have met with my Educational Supervisor to agree a work schedule.

I agree to work with the Trust Rota coordinator to agree my hours of duty at an appropriate percentage.

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| ***To be signed by the trainee:***  *In signing this form you are confirming that you have met with your Training Programme Director and Clinical/Educational Supervisor and agreed to your proposed work schedule. You are also bound by the eligibility guidelines for LTFT training and must inform us of any changes to your personal circumstances which may affect your eligibility criteria.***Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This document **MUST** be returned to (LTFT Administrator). **Failure to do so will result in the application not being progressed** |

Your contact at the Trust is (to be entered by LTFT Administrator)