***Private & Confidential***

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| **Return to Training: Initial Return Meeting Form** | | | | | | |
| **SECTION A (to be completed by the Trainee or ES or TPD)** | | | | | | |
| **Date of Initial Return Meeting:** Click here to enter text. | | | | | | |
| **Trainee Surname:** Click here to enter text. | **Trainee Forename:** Click here to enter text. | | | | | |
| **NTN:** Click here to enter text. | **GMC No:** Click here to enter text. | | | | | |
| **Specialty:** Click here to enter text. | **Grade (CT/ST etc):** Click here to enter text. | | | | | |
| **Educational Supervisor Name:** Click here to enter text. | **Training Programme Director Name:** Click here to enter text. | | | | | |
| **Place of training prior to absence:** Click here to enter text. | **Anticipated place of training on return:** Click here to enter text. | | | | | |
| **Date absence commenced:** Click here to enter text. | **Anticipated date of return:** Click here to enter text. | | | | | |
| **Reason for absence:** Click here to enter text. | | | | | | |
| **Intention to return to training Full Time or Less than full time (LTFT)?**  **If considering LTFT Please see our website for more details** <http://www.yorksandhumberdeanery.nhs.uk/policies/less_than_full_time/> | | | | **Full Time** | | **LTFT** |
| **Section B (to be completed by the ES or TPD)** | | | | | | |
| **Please provide detailed summery of the discussion between the Trainee and ES or TPD.** Discussion should include (but not limited to)   * CPD done whilst absent * Any work done during absence i.e. on calls, KiT days etc. * Sign posting to the YH SuppoRTT programme * Any concerns over returning * Learning & training needs (including possible assessments or courses that the trainee should attend)   Click here to enter text. | | | | | | |
| 1. **Is the trainee eligible for a Supernumerary Period?** (applicable for trainees who have been absent for a period of 6 months or more. In exceptional circumstances a supernumerary period may be requested for those who are not deemed as eligible) | | **Yes**  (complete 1.1,1.2,1.3 &1.4) | | **No**  (Move to section 2, unless claiming exceptional circumstances) | | |
| **Employing Trust on return (pays salary) (1.1)** Click here to enter text. | | | | | | |
| **Standard Hours (1.2):** Click here to enter text. | **Point on Salary Scale (1.3):** Click here to enter text. | | | | | |
| **Expected Supernumerary period dates (1.4):**  **From:** Click here to enter text. **To:** Click here to enter text.  If the expected length of supernumerary training needs to exceed the allocated three-day period, please indicate the reason why, including background information. Please note that this will require sign off from the SuppoRTT APD (section C).  **Background information and reason:** Click here to enter text. | | | | | | |
| 1. **Is a supervised return to training period necessary?** | | | **Yes**  (complete 2.1,2.2 & 2.3) | | **No**  (complete point 2.4) | |
| **(2.1) Please give details:** This must include details of the overall plan for supervised return to training period and the level of supervision required  Click here to enter text. | | | | | | |
| **(2.2) Required assessment(s) in this period:** These must include assessments of observed practice and may include workplace based assessments (WPBAs) and logbook evidence. *NB: details should be discussed with the clinical supervisor for the returning post*  Click here to enter text. | | | | | | |
| **(2.3) Date of Review Meeting:** Click here to enter text. | | | | | | |
| **(2.4) Reason for no period of increased supervision:** If, in *exceptional* circumstances, the decision has been made by both trainee and the Educational Supervisor / Training Programme Director that the supervised return to training period is unnecessary, please provide documentary evidence below that the trainee has maintained active clinical practice during the absence. If this is provided, then this form confirms that the trainee and Educational Supervisor are confident that the trainee can to return to “normal duties” from the date signed of this meeting  Click here to enter text. | | | | | | |
| **ES or TPD Name:** Click here to enter text.  **Signature: Date: Click here to enter text.** | | | | | | |
| **Trainee Name:** Click here to enter text.  **Signature: Date: Click here to enter text.** | | | | | | |
| **SECTION C (to be completed by the SuppoRTT APD/ DD if addition support has been requested)** | | | | | | |
| **SuppoRTT APD approval: Yes/ No, please provide details**  Click here to enter text.  **Signature: Date: Click here to enter text.** | | | | | | |

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| **Once completed please send a copy of this form to the TRAINING PROGRAMME DIRECTOR and the SuppoRTT Team (supportt.yh@hee.nhs.uk)**  **A copy also needs to be retained in your portfolio** |