**APPENDIX B: Return to Training Form: Initial Return Meeting**

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| **Please note; The ES/TPD\* responsible for having the Initial Return Meeting with the trainee will also be responsible for disseminating the trainees plan of return to all relevant educators/supervisors/medical education departments who will be responsible for the trainee during their return.**  **Please complete the form electronically.** |

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| **Return to Training: Initial Return Meeting Form** | | | | | | |
| **SECTION A (to be completed by the Trainee or ES/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. | | | | | |
| **Educator/Supervisor Name:**  Click here to enter text.  **Contact email address:**  Click here to enter text. | **FPD/TPD Name:**  Click here to enter text.  **Contact email address:**  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)?** | | | | **Full Time** | | **LTFT** |
| **Section B (to be completed by the ES or TPD)** | | | | | | |
| **Please provide detailed summery of the discussion between the Trainee and appropriate educator/supervisor.** Discussion should include (but not limited to)   * CPD done whilst absent * Any work done during absence i.e. on calls, KIT/SPLIT days etc. * Sign posting to internal/external Return to Training Activities * Any concerns over returning * Learning & training needs (including possible assessments or courses that the trainee should attend)   Click here to enter text. | | | | | | |
| **Date of Review Meeting: Click here to enter text.**  **Date of next ARCP: Click here to enter text.** | | | | | | |
| 1. **Is a Supernumerary Period required upon their return?** | | **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. | | | | | | |
| **Expected Supernumerary period dates (1.4):**  **From:** Click here to enter text. **To:** Click here to enter text.  **Total number of days:** Click here to enter text.  **Background information and reason:** Click here to enter text. | | | | | | |
| 1. **Is an enhanced supervised return to training period necessary?** | | | **Yes**  (complete 2.1,2.2 & 2.3) | | **No**  (complete point 2.4) | |
| **(2.1) Expected enhanced supervised period dates:**  **From:** Click here to enter text. **To:** Click here to enter text.  **Will this affect the trainees ability to work their scheduled shifts/contractual hours?** For example, will the trainee be able to work nights or be on call.  Click here to enter text. | | | | | | |
| **(2.2) 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. | | | | | | |
| **(2.3) 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. | | | | | | |
| **(2.4) Reason for no period of enhanced 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. | | | | | | |
| **Educator/Supervisor Name:** Click here to enter text.  **Email address:** 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 FOUNDATION/TRAINING PROGRAMME DIRECTOR and HEEYH SuppoRTT team**  **A copy also needs to be retained in your e-portfolio** |