**APPENDIX C: Return to Training Form: Review Meeting**

**This form should be used for ALL review meetings after the Initial Meeting**

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| **Return to Training: Review Meeting Form** | | | |
| **SECTION A (to be completed by the Trainee)** | | | |
| **Date of Review 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.  **Email address:**  Click here to enter text. | **FPD/TPD Name:**  Click here to enter text.  **Email address:**  Click here to enter text. | | |
| **Place of training prior to absence:** Click here to enter text. | **Place of training on return:** Click here to enter text. | | |
| **Date absence commenced:** Click here to enter text. | **Date of return:** Click here to enter text. | | |
| **Reason for absence:** Click here to enter text. | | | |
| **Section B (to be completed by the Trainee, ES or TPD)** | | | |
| **Please provide detailed summery of the discussion between the Trainee and appropriate educator/supervisor.** Discussion should include (but not limited to)   * Summary of observed assessments & logbook * Overall progress * Outstanding concerns * Any additional learning needs identified   Click here to enter text. | | | |
| **Extension to supernumerary and/or enhanced supervised return to training period required?** | | **Yes**  (complete,1,2,3) | **No** |
| **(1) Please give details:** This should include, reasons why a further period is required and details of the overall plan for extended supervised return to training period**.**  Click here to enter text. | | | |
| **(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. | | | |
| **(3) Date for further Review Meeting (if extension is required):**  Click here to enter text. | | | |
| **Date of next ARCP:** 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.** | | | |

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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** |