***Form R (Part A)***

**Trainee registration for Postgraduate Specialty Training**

**IMPORTANT:** If this form has been pre-populated by your Deanery/LETB, please check all details, cross out errors and write on amendments.

***By signing this document you are confirming that ALL details (pre-populated or entered by you) are correct.***

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| **Forename:** | Forename | | **GMC-registered surname:** | | | Surname as per GMC registration. | | | |
| **GMC number:** | GMC number | **Deanery/LETB:** | | | Enter Deanery/LETB or select from dropdown | | | | |
| **Date of Birth:** dd/mm/yyyy | | **Gender:** Please select. | | | | | |  | |
| **Medical School awarding primary qualification:** (name and country)  Click here to enter the name and country of your Medical School. | | | | | | | |
| **Primary Qualification and date awarded:**  Click here to enter your primary qualification and date awarded. | | | | | | | |
| **Current Home Address:**  Click here to enter your home address. | | | | | **Work Address:**  Click here to enter your work address. | | | | |
| **Home Phone / Mobile:** Enter home phone / mobile no. | | | | | **Work Phone / Mobile:** Enter work phone / mobile no. | | | | |
| **Preferred email address for all communications:** Click here to enter your email address. | | | | | | | | | |
| **Immigration Status:**  (e.g. resident, settled, work permit required)  Click here to enter your Immigration status. | | | | **Post Type or Appointment:**  (e.g. LAT, Run Through, FTSTA etc.)  Enter your Post Type or Appointment. If unknown, leave blank. | | | | | |
| **Programme Specialty:**  Click here to enter your programme specialty. | | | | **National Training Number:**  (to be completed by Postgraduate Dean on first registration)  To be completed by Postgraduate Dean. | | | | | |
| **GMC Programme Approval Number:**  (to be completed by Postgraduate Dean)  To be completed by Postgraduate Dean | | | | **Please tick only one of these three options :**  **I confirm I have been appointed to a programme leading to award of CCT**  **I confirm that I will be seeking specialist registration by application for a CESR**  **I confirm that I will be seeking specialist registration by application for a CEGPR** | | | | | |
| **Deanery Reference Number:**  (to be completed by Postgraduate Dean)  To be completed by Postgraduate Dean. | | | |
| **Specialty 1 for Award of CCT (if applicable):**  Click here to enter your first CCT specialty. | | | |
| **Specialty 2 for Award of CCT (if applicable):**  Click here to enter your second CCT specialty. | | | |
| **Provisional CCT Date, if known:**  (or CESR/CEGPR where applicable)  dd/mm/yyyy | | | | **Royal College/Faculty assessing training for the award of CCT:**  (if undertaking full prospectively approved programme)  Click here to enter the relevant Royal College/Faculty. | | | | | |
| **Initial Appointment to Programme:**  (Full time or % of Full time Training)  Click here to enter Full time or % Full time training. | | | | **Date of entry to Grade/Programme:**  (Substantive date started in programme of appointment)  dd/mm/yyyy | | | | | |
| I confirm that the information above is correct. | | | | | | | | | |
| **Trainee Signature:** | | Sign here. | | | | | **Date:** | | dd/mm/yyyy |
| **Signature of Postgraduate Dean**  **or representative of PGD:**  *(\*for Deanery/LETB use only upon return)* | |  | | | | | **Date:** | |  |

***Form R (Part B)***

**Self-declaration for the Revalidation of Doctors in Training**

**IMPORTANT:** If this form has been pre-populated by your Deanery/LETB, please check all details, cross out errors and write on amendments.

***By signing this document you are confirming that ALL details (pre-populated or entered by you) are correct.***

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| **Section 1: Doctor’s details** | | | | | | |
| **Forename:** | Forename | | | **GMC-registered surname:** | | Surname as per GMC registration. |
| **GMC number:** | GMC number | | **Deanery/LETB:** | | Enter Deanery/LETB or select from dropdown | |
| **Date of Birth:** dd/mm/yyyy | | **Gender:** Please select. | | | **Date of previous Revalidation (if applicable):**  dd/mm/yyyy | |
| **Name of previous Designated Body for Revalidation (if applicable):** | | | | | Enter your previous Designated Body (this should be your most recent Deanery/LETB, Trust or Area Team) | |
| **Specialty (e.g. Foundation, Core Medical Training, Anaesthetics, General Practice, Rheumatology, etc.):**  Click here to enter your programme specialty.  **If dual specialty, second specialty:** Click here to enter your second CCT specialty. | | | | | | |
| **Current Home Address:**  Click here to enter your home address. | | | | | | |
| **Home Phone / Mobile:** Enter home phone / mobile no. | | | | | | |
| **Preferred email address for all communications:** Click here to enter your email address. | | | | | | |

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| **Section 2: Whole Scope of Practice** | | | | | |
| **Read these instructions carefully!**  Please list all placements **in your capacity as a registered medical practitioner** **since your last ARCP/RITA or appraisal.**  This includes: (1) each of your training posts if you are or were in a training programme; (2) any time out of programme, e.g. OOP, mat leave, career break, etc.; (3) any voluntary or advisory work, work in non-NHS bodies, or self-employment; (4) any work as a locum. For locum work, please group shifts with one employer within an unbroken period as one employer-entry. Include the number of shifts worked during each employer-period.  *Please add more rows if required, or attach additional sheets for printed copy and entitle ‘Appendix to Scope of Practice’.* | | | | | |
| **Type of Work**  (e.g. name and grade of specialty rotation, OOP, maternity leave, etc.) | **Start Date** | **End Date** | **Was this a training post? Y/N** | **Name and location of Employing/ Hosting Organisation/GP Practice**  (Please use full name of organisation/site and town/city, rather than acronyms) | |
| Click here to enter type of work. | dd/mm/yyyy | dd/mm/yyyy | Select | Click here to enter employer details. | |
| Click here to enter type of work. | dd/mm/yyyy | dd/mm/yyyy | Select | Click here to enter employer details. | |
| Click here to enter type of work. | dd/mm/yyyy | dd/mm/yyyy | Select | Click here to enter employer details. | |
| Click here to enter type of work. | dd/mm/yyyy | dd/mm/yyyy | Select | Click here to enter employer details. | |
| Click here to enter type of work. | dd/mm/yyyy | dd/mm/yyyy | Select | Click here to enter employer details. | |
| **Time out of training: Trainee self-reported absence since last ARCP/RITA as mandated by the GMC:**  ‘Time out of training’ includes all forms of absence such as sickness, maternity, compassionate paid/unpaid leave, jury service, etc. You do not need to include study or annual leave or prospectively approved Out of Programme Training/ Research. | | | | | XX days |

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| **Section 3: Declarations relating to Good Medical Practice** | |
| These declarations are compulsory and relate to the Good Medical Practice guidance issued by the GMC.  **Honesty & Integrity** are at the heart of medical professionalism. This means being honest and trustworthy and acting with integrity in all areas of your practice, and is covered in Good Medical Practice.  A statement of **health** is a declaration that you accept the professional obligations placed on you in Good Medical Practice about your personal health. Doctors must not allow their own health to endanger patients. Health is covered in Good Medical Practice. |
| **1) I declare that I accept the professional obligations placed on me in Good Medical Practice in relation to honesty & integrity. Please select one of the following:**  Please tick/cross here to confirm your acceptance  *\* If you wish to make any declarations in relation to honesty & integrity, please do this in Section 6.*  **2) I declare that I accept the professional obligations placed on me in Good Medical Practice about my personal health.**  Please tick/cross here to confirm your acceptance  **3a) Do you have any GMC conditions or undertakings placed on you by the GMC, employing Trust or other organisation?**  Yes  Go to 3b)  No  Go to 4  **3b) If YES, are you complying with these conditions/undertakings?**  Yes  No  **4) Health statement**  Writing something in this section below is **not compulsory**. If you wish to declare anything in relation to your health for which you feel it would be beneficial that the ARCP/RITA panel or Responsible Officer knew about, please do so below.  Click here to provide details. |

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| **Section 4: Significant Events** | | | | |
| The GMC state that a significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.  All doctors as part of revalidation are required to record and reflect on Significant events in their work with the focus on what you have learnt as a result of the event/s. Use non-identifiable patient data only.  Please continue on a separate sheet if required and attach and entitle ‘Appendix to Significant Events’. | | | | |
| **\*\*REMINDER:** DO NOT INCLUDE ANY PATIENT-IDENTIFIABLE INFORMATION ON THIS FORM  **1) Please tick/cross ONE of the following only:**   * **I am NOT aware of any significant event investigations since my last ARCP/RITA/Appraisal** * **I am aware of significant event investigations since my last ARCP/RITA/Appraisal**   **2) If you know of any RESOLVED significant event investigations since your last ARCP/RITA/Appraisal, you are required to have written a reflection on these in your Portfolio. Please identify where in your Portfolio the reflection(s) can be found.** *(Add additional lines if required)*. | | | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Reflection/Event | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Reflection/Event | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Reflection/Event | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| **3) If you know of any UNRESOLVED significant event investigations since your last ARCP/RITA/Appraisal, please provide below a brief summary, including where you were working, the date of the event, and your reflection where appropriate. If known, please identify what investigations are pending relating to the event and which organisation is undertaking this investigation.**  Click here to provide details. | | | | |

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| **Section 5: Complaints** | | | | |
| A complaint is a formal expression of dissatisfaction or grievance. It can be about an individual doctor, the team or about the care of patients where a doctor could be expected to have had influence or responsibility.  As a matter of honesty & integrity you are obliged to include all complaints, even when you are the only person aware of them.  All doctors should reflect on how complaints influence their practice. Use non-identifiable patient data only. | | | | |
| **\*\*REMINDER:** DO NOT INCLUDE ANY PATIENT-IDENTIFIABLE INFORMATION ON THIS FORM  **1) Please tick/cross ONE of the following only:**   * **I am NOT aware of any complaints since my last ARCP/RITA/Appraisal** * **I am aware of complaints since my last ARCP/RITA/Appraisal**   **2) If you know of any RESOLVED complaints since your last ARCP/RITA/Appraisal, you are required to have written a reflection on these in your Portfolio. Please identify where in your Portfolio the reflection(s) can be found.** *(Add additional lines if required)*. | | | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Complaint | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Complaint | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Complaint | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| **3) If you know of any UNRESOLVED complaints since your last ARCP/RITA/Appraisal, please provide below a brief summary, including where you were working, the date of the complaint/incident, and your reflection where appropriate. If known, please identify what investigations are pending relating to the complaint and which organisation is undertaking this investigation.**  Click here to provide details. | | | | |

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| **Section 6: Other Investigations** | | | | |
| In this section you should declare any on-going investigations, such as honesty, integrity, conduct, or any other matters that you feel the ARCP/RITA/Appraisal panel or Responsible Officer should be made aware of. Use non-identifiable patient data only. | | | | |
| **\*\*REMINDER:** DO NOT INCLUDE ANY PATIENT-IDENTIFIABLE INFORMATION ON THIS FORM  **1) In relation to being subject to any other investigation of any kind since my last ARCP/RITA /Appraisal, please tick/cross ONE of the following only:**   * **I have nothing to declare** * **I have something to declare**   **2) If you know of any RESOLVED investigations since your last ARCP/RITA/Appraisal, you are required to have written a reflection on these in your Portfolio. Please identify where in your Portfolio the reflection(s) can be found.** *(Add additional lines if required)*. | | | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Issue | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Issue | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| Date of entry in Portfolio | dd/mm/yyyy | | Title/Topic of Issue | Click here to provide details. |
| Location of entry in Portfolio | | Click here to provide details. | | |
| **3) If you know of any UNRESOLVED investigations since your last ARCP/RITA/Appraisal, please provide below a brief summary, including where you were working, the date of the incident/investigation, and your reflection where appropriate. If known, please identify what investigations are pending relating to the matter and which organisation is undertaking this investigation.**  Click here to provide details. | | | | |

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| **Section 7: Compliments** |
| Compliments are another important piece of feedback. You may wish to detail here any compliments that you have received which are not already recorded in your portfolio, to help give a better picture of your practice as a whole. Please use a separate sheet if required. **This section is not compulsory.** |
| **\*\*REMINDER:** DO NOT INCLUDE ANY PATIENT-IDENTIFIABLE INFORMATION ON THIS FORM  Click here to provide details. |

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| I confirm this is a true and accurate declaration at this point in time and will immediately notify the Deanery/LETB and my employer if I am aware of any changes to the information provided.  I give permission for my past and present ARCP/RITA portfolios and / or appraisal documentation to be viewed by my Responsible Officer and any appropriate person nominated by the Responsible Officer. Additionally if my Responsible Officer or Designated Body changes during my training period, I give permission for my current Responsible Officer to share this information with my new Responsible Officer for the purposes of Revalidation. | | | |
| **Trainee Signature:** | Sign here. | **Date:** | dd/mm/yyyy |