# GP Intra-Deanery Transfer Application Form

Please complete this form in BLOCK CAPITALS and Black Ink and submit to your current Training Programme Director. Approval of an intra-deanery transfer application does not guarantee a placement in another programme.

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| Current Training Programme: |       | **GMC Number:** |       |
| Proposed Training Programme: |       | **NTN Number:** |       |
| **Date of Proposed Transfer:** **Transfer date will normally be the usual changeover date in the GP rotation (February or August)** | dd | mm | yyyy |
|  |    |    |      |

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| CONTACT DETAILS: |
| **Last name:** |       | **First name:** |       |
| **Current Address:**for correspondence |       |
| **Postcode:** |       |
| **Telephone No:** |       | **Mobile No:** |       |
| **E-mail:** |       |

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| ASSESSMENT: |
| Have you attempted any examination components of the MRCGP? AKT [ ]  CSA [ ] If **yes**, please give details of components attempted, dates, and results if known.      |
| GMC AND OCCUPATIONAL HEALTH |
| Are you currently the subject of a GMC referral or investigation? YES [ ]  NO [ ] If **yes**, please give details of dates, subject matter and current situation     Have you been referred to Occupational Health during your GP training? YES [ ]  NO [ ] If **yes**, please give details of dates and reason     **Have any concerns been raised at any point during your GP training about your professional revalidation? YES** [ ]  **NO** [ ]  If **yes**, please give details of dates and reason      |

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| CURRENT GPST SCHEME: |
| **Date of Appointment to GPST:** | dd | mm | yyyy | **Expected date of completion of GPST:** | dd | mm | yyyy |
|  |    |    |      |  |    |    |      |
| **CURRENT POST:** |
| **ST** [ ]  **Specialty:**       **Hospital** **[ ]  Practice**:       | Full time [ ]   Part time [ ]  | **Start date:** |    |    |      |
|  |  | **Finish date:** |    |    |      |
| POSTS COMPLETED AS PART OF GPST Training*Please include any periods of sick leave (over 10 days in one ST year), Maternity/Paternity leave or any approved Out of Programme (OOP)* |
| **Specialty (please include hospital or practice name):** | If part time please supply percentage  | **Start Date** | **End Date** |
|  |  | dd | mm | yyyy | dd | mm | yyyy |
|       | Full time [ ]  Part time [ ]  |    |     |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |
|       | Full time [ ]  Part time [ ]  |    |    |      |    |    |      |

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| **TRAINING REQUIREMENTS:** *Please confirm how much further training (whole time equivalent) you will require in order to complete your GP training from the proposed transfer date* |
| **GP Practice Post** | 6 months [ ]  | 12 months [ ]  | 18 months [ ]  |
| **Hospital Post** | 6 months [ ]  | 12 months [ ]  | 18 months [ ]  |
| Are you currently training less than full time? | YES [ ]  NO [ ]  |
| Do you wish to complete your training less than full time?See application form and policy on the GP School website (<http://www.yorksandhumberdeanery.nhs.uk/general_practice/trainees/gp_school_policies_and_organisation/>) | YES [ ]  NO [ ]  |

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| REASON FOR REQUESTING A TRANSFER: *You should provide a detailed case outlining your circumstances and reasons for requesting a transfer.*  |
| Please highlight the reason(s) from the criteria below as applicable and give further information to support your request stating **when these changes took place / are to take place. Changes are only deemed relevant IF they occurred after the date of appointment onto the GP scheme**You should attach a more detailed explanation of the reasons for requesting the transfer (one side of A4)  **Please ensure you provide all supplementary evidence**1. Significant life event
2. Caring responsibilities
3. Committed relationship – e.g. Marriage, civil partnership
4. Other relationships, support networks
5. Length of Rotation
6. Impact on well being
7. Change of Location of spouse/partner (where partner has no choice in changing length or location of their employment).

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| SIGNATURE: Please sign and date this form and submit to your current Training Programme Director |
| I hereby formally apply to transfer to       Training Programme and confirm all above information is correct. If this information is subsequently found to be untrue, this will be considered a probity issue and may be referred to the GMC. I am aware that a deanery panel will meet to review this application. I acknowledge that I have a right of appeal if the panel decides I do not meet the criteria for transfer. However I understand that even if I meet the criteria for transfer and there are no vacant posts available my application will be refused on those grounds and I do not have the right of appeal. |
| Signature …………………………………………………… | Date: |     / |    / |      |

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| TO BE COMPLETED BY HEYH PROGRAMME SUPPORT (before SMT consideration) |
| Latest ARCP Panel Review YES [ ]  NO [ ] Leave Calculator (if applicable)  **YES [ ]  NO** [ ] Other centrally held documentation **YES [ ]  NO** [ ] If **YES**, please give details:        |
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| To be completed by current Training Programme Director |
| Please provide details of progression within GP training so far, including any issues or concerns you may wish to raise:     Do you approve and support this trainee’s application for a transfer?If **NO**, please give reasons:       | **YES [ ]  NO** [ ]  |
| Signature ………………………………………………………………. Date    /    /     **NAME**  |

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| To be completed by a member of the GP Senior management team after review |
| Intra deanery transfer approved? | **YES [ ]  NO** [ ]  |
| If **NO**, please state reason:      **Deputy Director Signature**  ……………………… **NAME** ………………………...Date / / **Deputy PG Dean Signature**  ……………………… **NAME** ………………………  Date / /  |
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| To be completed by receiving Training Programme Director |
| Is your programme able to accommodate this intra-deanery transfer application? | **YES [ ]  NO** [ ]  |
| If **NO**, please give reasons:       |
| If **YES**, please confirm post and start date in your GP ST Programme  |  | Start date:    /    /       |
| Signature ………………………………………………………………. Date    /    /     **NAME:       GP ST Programme:** |