Please **fully** complete this Application Form to apply for an **Academic Teaching Fellowship** within the **Health Education England Yorkshire and Humber School of Psychiatry**. Please do not type/write using only capital letters and please remember to check it carefully, as once the form has been submitted it cannot be changed. Please note that questions marked with an asterisk \* are mandatory and therefore must be answered.

# APPLICATION FORM

# Psychiatry Academic Teaching Fellowship

|  |  |
| --- | --- |
| Post Reference |  |
| Post Title |  |

**Personal Details**

|  |  |
| --- | --- |
| Title |  |
| Family Name / Last Name |  |
| First Name |  |
| Address |  |
| Postcode / Zip code |  |
| Country |  |
| Home Telephone |  |
| Mobile Telephone |  |
| Work Telephone |  |
| Preferred telephone number | ☐ Home ☐ Mobile ☐ Work |
| Email Address |  |

**Right to Work in the UK**

|  |
| --- |
| **\***Are you a United Kingdom (UK) or European Economic Area (EEA) National? |
| ☐ Yes ☐ No |
| **\***Do you require Tier 2 sponsorship to undertake this post? |
| ☐ Yes ☐ No |
| For more information about Tier 2 visas, please see [gov.uk](https://www.gov.uk/tier-2-general). |

**Current Employment / Training Post Details**

|  |  |
| --- | --- |
| Job Title |  |
| Employer Name |  |
| Address |  |
| Postcode |  |
| Country |  |
| **For current Medical, Dental and Pharmacy trainees** **only:** | |
| NTN (if applicable) |  |
| Name of School |  |
| Name of Specialty |  |
| Current Training Grade |  |

**Professional Registration**

|  |  |
| --- | --- |
| **For Medical, Dental and other clinical staff only.** Please give details of your professional registration eg GMC, GDC, UKCC | |
| Professional Body |  |
| Membership/Registration Number |  |
| Membership Status |  |
| Expiry/Renewal Date |  |

**Education & Professional Qualifications**

|  |  |  |  |
| --- | --- | --- | --- |
| Please list all relevant academic and professional qualifications. Please also indicate subjects currently being studied. All qualifications disclosed will be subject to a satisfactory check. | | | |
| Qualification | Grade/result | Place of Study | Year obtained |
|  |  |  |  |
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**Training and Continuing Professional Development**

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| --- |
| Please list any relevant additional training or competences that you would like us to consider in relation to your application. |
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**References**

Please provide the names and full details of two people who have agreed to supply references. One of whom must be your present or most recent employer. References will only be collected after interview.

**Referee 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | | |
| Last Name |  | First Name |  |
| Relationship to you |  | | |
| Employer Name |  | | |
| Referee Job Title |  | | |
| Employer Name |  | | |
| Address |  | | |
| Postcode |  | | |
| Contact Number |  | | |
| Email Address |  | | |

**Referee 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | | |
| Last Name |  | First Name |  |
| Relationship to you |  | | |
| Employer Name |  | | |
| Referee Job Title |  | | |
| Employer Name |  | | |
| Address |  | | |
| Postcode |  | | |
| Contact Number |  | | |
| Email Address |  | | |

**Supporting Statement**

|  |
| --- |
| Please provide a statement giving your reasons for applying and outlining your suitability for the post. Your supporting statement must be no more than one page of A4. |
|  |

**Declaration**

The information in this form and in any attachments is true and complete. I agree that any deliberate omission, falsification or misrepresentation in the application form will be grounds for rejecting this application or subsequent dismissal if employed by the organisation. Where applicable, I consent that the organisation can seek clarification regarding professional registration details. If successful, I consent to my application being shared with the Health Education England School of Psychiatry, Division of Psychological and Social Medicine University of Leeds and Academic Department of Medical Education University of Sheffield.

|  |  |  |  |
| --- | --- | --- | --- |
| I agree to the above declaration | | | |
| Signature |  | | |
| Name |  | Date |  |

*[If you agree please enter your full name. If invited to interview, you will be asked to sign the form.]*

To submit your application please send your completed Application Form and a copy of your CV to the School of Psychiatry email address; [psychiatry.yh@hee.nhs.uk](mailto:psychiatry.yh@hee.nhs.uk). **Please** **note: CVs sent without a fully completed Application Form will not be accepted.**