PLEASE COMPLETE IN CAPITAL LETTERS \* = mandatory field

|  |  |
| --- | --- |
| Full Name of Applicant\*: |  |
| Current Job Title\*: |  |
| Preferred Job Title: |  |
| Place of Work\*: |  |
| CCG/Locality\*:  |  |
| NHS Email\*: |  |
| Additional email: |  |
| Telephone number\*: |  |

**COURSE REQUEST\*\*** *If interested in more than one course, please list in order of preference*

|  |  |
| --- | --- |
| **Course Title** | **Location/Preferred Provider** |
|  |  |
|  |  |
|  |  |

 *\*\*Note: funding for all course applications are reviewed to ensure a fair and equitable approach for all Primary Care Staff within the Mid & South Essex HCP. Please note that the return of an EOI form does NOT denote automatic course approval.*

**Please provide a short summary of why this supports your Professional Development:**

|  |
| --- |
| How would you and patients benefit from this training? |
|  |
| Previous Accreditations *(if applicable)* |
|  |

**To be signed by applicants’ Line Manager, Practice Manager or Practice Partner**

I authorise the above individual to participate in the identified course and the time commitment required to complete the necessary requirements

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Position: |  |
| Signature: |  | Date: |  |

*Please note that non-attendance of any course that has been booked may incur a penalty without sufficient notice being given.*

**To be signed by applicant**

By signing this form I agree to the terms stated. I understand that the Training Hub may request confirmation of employment within Mid & South Essex HCP. It is my responsibility to notify the Training Hub of any updates to training requirements.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |