This form will be used to confirm the elements of your Supported Return to Training package that will be funded. After discussing and agreeing your return to Training, a funding request form (Form 4) must be discussed with and signed by your Training Programme Director or College Tutor and submitted the postgraduate admin team.

|  |
| --- |
| **Form 2 – Planning your Return to training*this meeting should take place 3 months prior to your anticipated return date*** |
| **Trainee Name:** |  | **GMC Number:** |  |
| **Return Placement**  |  | **Educational Supervisor:** |  |

|  |  |
| --- | --- |
| **Reason for Absence:** |  |
| **Provisional Date of Return To Training** |  |

|  |  |  |
| --- | --- | --- |
| **Intention to return to training Full Time or LTFT?** | **Full Time** | **LTFT** |
|  |  |

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| **Summary of discussion between trainee and Educational Supervisor:****Please consider the following:*** **Anything done to keep up to date whilst out of training for example KIT Days / Return to Clinical Practice courses**
* **Any particular concerns over returning**
 |
|  |
| **Overview of plan for supervised return to work period:****You should document whether or not an enhanced supervision period will be required, details of the course which the trainee will be attending and any other mandatory actions for the trainee prior to return**  |
|  |
| **Required assessments in this period:****These must include assessments of observed practice, and may include workplace based assessments (WPBAs) and logbook evidence** |
|      |

|  |  |
| --- | --- |
| **Provisional Date of Return Review Meeting****This should be approximately 2 weeks after return:** |  |

**Trainee declaration**

By inserting my name below, I confirm that the information provided is correct and I have not made any other claim for the expenses listed in this application. I understand if I knowingly provide false information I may be liable for prosecution and civil recovery proceedings. This may result in disciplinary action and referral to the GMC.

|  |  |  |  |
| --- | --- | --- | --- |
| **Trainee Name** |  | **Date**  |  |

**TPD or College Tutor declaration**

By inserting my name below, I confirm that I have discussed and agreed to this activity in the individualised SuppoRTT plan with the trainee and I confirm that I will facilitate the return to clinical practice.

|  |  |  |  |
| --- | --- | --- | --- |
| **TPD / College Tutor**  |  | **Date**  |  |