

**Notification of Completion of Training**

*This form is only to be used by ICM Specialty Registrars (StRs) who are expected to complete their Stage 3 ICM training for the award of a Certificate of Completion of Training [CCT] or a Certificate of Eligibility for Specialist Registration [Combined Programmes] [CESR[CP]] within four months. It must be completed in BLOCK CAPITALS*

**Personal Details**

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| Surname |  | | |
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| Forenames |  | Gender |  |

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| Permanent Address for Correspondence: | | |
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| Town: | County: | Postcode: |
| Daytime Telephone Number: | | |
| Email Address: | | |

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| GMC Number | |  | |  |  | | |  | |  | | |  | | |  | |
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| College Reference Number | | | | | | |  | |  | | |  | |  | | |  | |  |

**Fellowship**

**FFICM**

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| Date of Award | M | M | Y | Y | Y | Y |

**Medical Qualifications**

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| **Primary Medical Qualification** | **Country Obtained** | **City Obtained** | **Year** |
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**Postgraduate Professional Training (***Please complete in full)*

Please list in chronological order all the Stage 1, Stage 2, and Stage 3 posts which are being credited towards the CCT/CESR[CP]. Include periods of training in research, overseas, LAT, FTTA if they are being credited towards the CCT/CESR[CP]. If you are a Dual Trainee please include details of you Higher Specialty Training for your partner specialty also.

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| **Grade/Title of Post** | **Commencement and completion dates**  **DD/MM/YY** | **Fulltime/Flexible**  **(*% of WTE for Flexible)*** | **Permanent/**  **LAT/FTTA** | **Name of Hospital or Medical School** | **Content of Training**  **(*Please list all modules of training undertaken i.e. PICU, CICU, NICU, SPECIAL SKILLS)*** |
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***Postgraduate Professional Training Continued*** *(Continue on another sheet if necessary)*

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| **Grade/Title of Post** | **Commencement and completion dates**  **DD/MM/YY** | **Fulltime/Flexible**  **(*% of WTE for Flexible)*** | **Permanent/**  **LAT/FTTA** | **Name of Hospital or Medical School** | **Content of Training**  **(*Please list all modules of training undertaken i.e. PICU, CICU, NICU, SPECIAL SKILLS)*** |
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| **Post CCT intentions Survey**  When you complete your CCT, what are your intentions?  Complete a fellowship  Apply for a Consultants post in the UK  Migrate and practice medicine outside of the UK  Other  *If other Please specify*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

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| **Completion of training**  I confirm that the details given are an accurate reflection of my training programme in ICM and where required, a partner specialty.  **ICM Specialty Registrar’s Signature: …………………………………… Date: ………………………………** |

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| **Endorsement by Programme Co-ordinator\***  I confirm that the above doctor has undergone and passed all the required assessments and has achieved as a minimum the core clinical learning outcomes for the award of a Certificate of Completion of Training or the Certificate of Eligibility for Specialist Registration [Combined Programmes] in Intensive Care Medicine. I will notify the Faculty of Intensive Care Medicine Training Department if there is any change to this confirmation between now and the formal completion of training. | | | | | | | | |
| The date of completion of training will be: | D | D | M | M | Y | Y | Y | Y |  |
| **Programme Co-ordinator\***  Name *(Block Capitals)*: ……………………………………………………………………………………………………………………………..  Signature: …………………………………………………………… Date: ………………………………………..  \* The Programme Co-ordinator will be the Regional Adviser or Training Programme Director (or their appointed deputies) | | | | | | | | |

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| Once this notification form has been completed and signed, please send the form to: [**contact@ficm.ac.uk**](mailto:contact@ficm.ac.uk) |