

**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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| NTN |  |  |  |  |
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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** |