# APPENDIX 8

**Application to Confirm Eligibility to train Less Than Full Time (LTFT)**

**DENTAL SPECIALTY TRAINEES**

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| **Date of Application for Less Than Full Time Training** |  |
| **Full Name** |  | **Title** |  |
| **Address** |  |
|  |  | **Postcode** |  |
| **Home Tel. Number** |  | **Mobile No.** |  |
| **E-Mail Address** |  | **GDC No:** |  |
| **Are you on a Tier 2 Visa? Delete as appropriate: YES / NO** |
| **Date of appointment to training scheme** |  |
| **Specialty Training Programme** |  |
| **Current Trust/ Employer** |  | **Training Grade** |   |
| **Start Date** |  | **CCST Date** |  |
| **Name of Training Programme Director** |
| **Proposed date to commence Part Time Training** |
| **Proposed working percentage (%)** |
| **Planned return to work date if on maternity leave**  |

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| --- |
| **SIGNATURE:** Please sign and date this form and submit to the relevant office |
| **I hereby formally apply for Part Time Training and confirm all the information on this form is correct.** Signature ………………………………………………………………………… Date ......../…….…./……...**I support this application form** **Part Time Training (Training Programme Director)**Signature ……………………………………………………………………… Date ….…/………../……… |

**What next?**

* Have you fully completed the form? Please double check, giving as much information as possible.
* Return the form along with a copy of your most up to date CV and appropriate supporting documents to the appropriate person as your local policy dictates

|  |  |  |
| --- | --- | --- |
| **FOR OFFICE USE:**  | **Yes**  | **No**  |
| Application Supported  |  |  |
| **Signature/s****……………………………………………… Postgraduate Dental Dean** |