# APPENDIX 8

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

**DENTAL SPECIALTY TRAINEES**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | |