**EXPRESSION OF INTEREST LoC SDI-IO**

Thank you for your interest in the LoC SDI-IO with Teesside Cheshire West and Chester. Please complete the details below

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and postcode of place of work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current UK GMC & licence to practise / NMC number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details regarding the mandatory requirements needed prior to commencing training have been sent to you along with this form. Please complete the information below and return with your application.**

**CERTIFICATES OF EVIDENCE ARE REQUIRED AS BELOW AS FSRH THESE MUST BE PRESENTED TO THE TRAINER PRIOR TO ANY TRAINING BEING COMMENCED. PLEASE NOTE: TRAININIG CANNOT COMMENCE UNTIL ALL THE EVIDENCE BELOW HAS BEEN SUPPLIED**

|  |  |  |  |
| --- | --- | --- | --- |
| **BLS** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **ANAPHYLAXIS** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **MODULE 3 ON e-LFH**  **to be completed within 3 months of training commencing** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **MODULE 14 ON e-LFH**  **to be completed within 3 months of training commencing** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **DBS CERTIFICATE** | **Date:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **CONTRACEPTION COUNSELLING FSRH COURSE**  **Not required if you hold the DFSRH / MFSRH** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **SAFEGUARDING ADULTS**  **Level 2** | **Date completed:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **SAFEGUARDING CHILDREN**  **Level 3** | **Date completed:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **IMMUNISATION EVIDENCE** | **Hepatitis B** | **CERTIFICATE UPLOADED** | **YES / NO** |

|  |  |
| --- | --- |
|  | **Signature to self-certify competence** |
| **Competent in consultation skills** |  |
| **Competent to give intramuscular injection** |  |
| **Conversant with current FSRH guidance on subdermal implants** |  |

Training is provided free of charge to services who are sub-contracted to HCRG Sexual Health Cheshire West and Chester.

For those who are not sub-contracted a payment of **£300** will be charged.

This payment is due before commencement of your training.

Please provide the details requested below for invoicing if different to the details already provided above

Name

Role

Company name

Address/Postcode

Contact number

Email address

PO (if applicable)

Please return all completed forms to [CWCSH@hcrgcaregroup.com](mailto:CWCSH@hcrgcaregroup.com)

Thank you

We look forward to training you.