**EXPRESSION OF INTEREST LoC SDI-IR (insertion & Removal)**

Thank you for your interest in the LoC SDI-IR with Cheshire West and Chester Sexual Health.

In order to progress with your training, could you kindly complete the following form.

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 FOR THE BELOW**

|  |  |  |  |
| --- | --- | --- | --- |
| **BLS**  | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **ANAPHYLAXIS** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **MODULE 3 Contraceptive Choices on e-LFH** **to be completed within 3 months of training commencing** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **MODULE 14 Implants on e-LFH** **to be completed within 3 months of training commencing** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **eKA/OTA/FSRH DIPLOMA most recent certification** | **Date achieved:** | **CERTIFICATE UPLOADED** | **YES / NO**  |
| **Be up to date with levels 1-3 safeguarding children AND young people and ensure maintained throughout training** | **Date:** | **CERTIFICATE UPLOADED** | **YES / NO** |
| **DBS CERTIFICATE** | **Date:** | **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.

***The above payment is independent to the payments required to FSRH which we have no control over.***

***The fees payable to the FSRH can be found on the information sheet.***

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

Thank you

We look forward to training you.