Appendix 1- application form

**Application- New to Practice Fellowship Funding**

**Your Details**

|  |  |
| --- | --- |
| **Title** |  |
| **Full Name** |  |
| **E-mail address** |  |
| **Contact telephone number** |  |
| **Professional Role** |  |
| **Date of Qualifying\*** |  |

\*Programme available to those qualified from November 2018 onwards for 2020.

**Your Practice Details**

|  |  |
| --- | --- |
| **Employing Practice Name** |  |
| **Number of sessions or hours employed** |  |
| **Practice Manager Name** |  |
| **Practice Manager E-mail** |  |
| **Name of Approving manager/partner** |  |

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| --- |
| **Please provide a brief outline of your aims for this programme. This should include how you intend to use the weekly protected CPD time and how this links to your practice/PCN population health needs.** |
|  |

Please ensure this form is signed by both applicant and authorising Practice Manager/Practice Partner. The authorising manager consents to the GP or practice nurse accessing the programme funding and support, and will also be required to sign a Memorandum of Understanding which will detail the invoicing terms.

