**Supporting Mentors Scheme Application**

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| **Name of GP applicant** |  |

**Personal details**

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| --- | --- | --- | --- | --- |
| **Home address** |  | | | |
| **Telephone** |  | **Email** |  | |
| **GMC number** |  | **Are you on the National Medical Performers List?** | Yes |  |
| No |  |
| **Qualifications and dates.**  **Please include any relevant mentoring qualifications.** | **Qualification** | **Date** | **Awarding organisation** | |
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**Scheme application**

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| **What are your personal objectives in applying to this scheme?** |
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| **Why is mentoring others important to you?** |
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| **Please provide examples of any recent actions you have taken to support the development of others.** |
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| **Please provide details of any previous mentoring experience and the outcomes achieved (if any).** |
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**Employing Practice details**

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| --- | --- | --- | --- |
| **Proposed start date** |  | **Number of clinical sessions per week** |  |
| **Name of employing practice** |  | | |
| **Practice address** |  | | |

**Agreement**

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| **I understand that if I am accepted on this scheme, I will need to commit to attendance at relevant accredited training if required, and in addition that I agree to the terms of engagement for delivering mentoring over the subsequent 12 months.**  **I confirm that the information given in this form is accurate and is consistent with the criteria of the Supporting Mentors Scheme and that information contained in this form will be shared with NHS England for the purposes of monitoring the scheme.** | | | |
| Name of prospective GP mentor |  | | |
| Signature of prospective GP mentor |  | Date |  |
|  | | | |
| **On behalf of the employing practice, I confirm that the doctor currently undertakes a minimum of 3 clinical sessions at the practice on an employed or partnership basis.** | | | |
| Name of authorising employer (e.g. practice manager) |  | | |
| Signature of authorising employer (e.g. practice manager) |  | Date |  |