

APPLICATION FOR TASTERS

To be submitted at **least six weeks** prior to educational activity.

Full Name:	
-------------------	--

Email:		Contact telephone/bleep:	
---------------	--	---------------------------------	--

Current speciality:	
----------------------------	--

Training Programme:	
----------------------------	--

Educational Supervisors name	
-------------------------------------	--

TASTER DETAILS	
Specialty:	
Location:	
Taster Supervisors Name:	

	From:	To:	No of days:
Dates of proposed leave			

YOU MUST ARRANGE COVER FOR YOUR CLINICAL COMMITMENTS PRIOR TO SUBMITTING THE FORM. LOCUMS CANNOT BE ARRANGED.

Commitments to be covered (please specify):
 If internal cover required, who has agreed to cover you?

--

Objectives of the 'Taster Experience:

- 1.
- 2.
- 3.

Proposed Clinical Timetable for your Taster Session:

Day	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					

APPROVALS	
------------------	--

Rota Manager's signature:	
Date:	

Educational Supervisor name/Signature: (Educational confirmation)	
Date:	

Taster Supervisor name/Signature: (Educational confirmation)	
Date:	

<i>I confirm that this application for a 'taster' experience has been approved and the number of days should be subtracted from this trainees study leave allocation.</i>	
Foundation Programme Director: (Educational confirmation)	
Date:	

Applicant Signature:	
Print name:	
Date:	

PLEASE SUBMIT YOUR COMPLETED APPLICATION FORM TO THE MEDICAL EDUCATION DEPARTMENT FOR PROCESSING.

Director of Medical Education name/signature:	
Print name:	
Date:	