The Faculty of Intensive Care Medicine

Notification of Completion of Training

This form is only to be used for those trainees who are expected to complete their Stage 3 ICM training for the award of a Certificate of Completion of Training [CCT] Certificate of Eligibility for Specialist Registration[Combined Programmes] [CESR[CP]] within four months. It must be completed in BLOCK CAPITALS

Personal Details

Surname	

Forenames		Gender	

Permanent Address for Correspondence:		
Town:	County:	Postcode:
Daytime Telephone Number:		
Email Address:		

Date of Birth	

NTN				

GMC Number							

College Reference Number						

Fellowship

FFICM ☐

Date of Award	M	M	Y	Y	Y	Y

Medical Qualifications

Primary Medical Qualification	Country Obtained	City Obtained	Year

Postgraduate Professional Training (*Please complete in full)*

Please list in chronological order all the Stage 1, Stage 2, and Stage 3 posts which are being credited towards the CCT/CESR[CP]. Include periods of training in research, overseas, LAT, FTTA if they are being credited towards the CCT/CESR[CP]. If you are a Dual Trainee please include details of you Higher Specialty Training for your partner specialty also.

Grade/Title of Post	Commencement and completion dates DD/MM/YY	Fulltime/Flexible (*% of WTE for Flexible)*	Permanent/ LAT/FTTA	Name of Hospital or Medical School	Content of Training (*Please list all modules of training undertaken i.e. PICU, CICU, NICU, SPECIAL SKILLS)*

Postgraduate Professional Training Continued *(Continue on another sheet if necessary)*

Grade/Title of Post	Commencement and completion dates DD/MM/YY	Fulltime/Flexible (*% of WTE for Flexible)*	Permanent/ LAT/FTTA	Name of Hospital or Medical School	Content of Training (*Please list all modules of training undertaken i.e. PICU, CICU, NICU, SPECIAL SKILLS)*

Post CCT intentions Survey

When you complete your CCT, what are your intentions?

Complete a fellowship ☐

Apply for a Consultants post in the UK ☐

Migrate and practice medicine outside of the UK ☐

Other ☐

If other Please specify

_____

Completion of training

I confirm that the details given are an accurate reflection of my training programme in ICM medicine and where required a partner specialty.

Trainees Signature: …….. Date: ……

Endorsement by Programme Co-ordinator*

I confirm that the above doctor has undergone and passed all the required assessments and has achieved as a minimum the core clinical learning outcomes for the award of a Certificate of Completion of Training or the Certificate of Eligibility for Specialist Registration [Combined Programmes] in Intensive Care Medicine. I will notify the Faculty of Intensive Care Medicine Training Department if there is any change to this confirmation between now and the formal completion of training.

The date of completion of training will be:

D	D	M	M	Y	Y	Y	Y

Programme Co-ordinator*

Name *(Block Capitals)*: ……..

Signature: …….. Date: ……..

* The Programme Co-ordinator will be the Regional Adviser or Training Programme Director (or their appointed deputies)

Once this notification form has been completed and signed, please forward the form to:

Faculty of Intensive Care Medicine
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London WC1R 4SG

Direct Line: 020 7092 1688
E-mail: rmakwana@ficm.ac.uk
Training email address : contact@ficm.ac.uk