**Advanced Clinical Practice (ACP) Programme: Notification of Change**

**Transfer to New Employing Organisation/Temporary withdrawal or Leave of Absence (LoA) or complete withdrawal from ACP Programme**

**To:** SYB Faculty for Advanced Clinical Practice

**This form should be completed following a discussion with your supervisor, as soon as possible before any changes are to be introduced**

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| **Name of Trainee** |  | |
| **Name of University** | | **Cohort start date** |
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| --- | --- | --- |
| **Details of modules already completed and those still outstanding, with dates (to be completed by trainee ACP and current employer/HEI representative module/programme lead)** | | |
| **Modules Completed** | **Date of completion** | **Modules still outstanding (with estimated completion dates if known)** |
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| **Clinical Academic Support Panel (CASP meeting)** | | |
| **Date of most recent Clinical Academic Support Panel (CASP meeting)** | **CASP Outcome: 1 – 6** | **Comments** |
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| **Reasons for this change (to be completed by trainee ACP and HEI representative module/programme lead)** | | |
| **Temporary withdrawal or Leave of Absence (LoA):** | **Date of change:**  **Date to meet to plan return to programme:** | |
| **Please write brief details here:** | | |
| **Complete withdrawal:** | | **Date of change:** |
| **Please write brief details here:** | | |

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| **Change of employer/details of new practice role:** | **Date of change:** |
| **Please write brief details here:** | |

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| **Existing employer name and details:** | **New employer name and details:** | **Start date:** |
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**CONFIRMATION OF UNDERSTANDING (please complete as appropriate)**

1. **ACP Trainee**

I confirm that (please delete as appropriate) :

**Temporary withdrawal or Leave of Absence (LoA):**

* I have discussed and understand the implications of temporarily withdrawing/agreeing a Leave of Absence (LoA) with the HEI and have discussed this with my employer/supervisor

**Change of employer**

* I have advised my new employer that any funding for ACP educational fees and any remaining, associated training grant is subject to new HEE approval and any funding currently supporting me may not transfer to my new employer
* I plan to commence my new role, with my new employer on the date stated above
* I have completed the CASP process and details as required (on page 1 of this form)

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| **Signed** |  | **Date** |  |

1. **Current employer (including employing GP Practice)**

We confirm and understand that:

**Temporary withdrawal or Leave of Absence (LoA):**

* I have discussed and understand the implications of temporarily withdrawing/agreeing a Leave of Absence (LoA) with the HEI and have discussed this with my employer/supervisor

**Change of employer**

* Any right to claim a training grant for the ACP trainee will cease on their last day of employment with us
* Any new/replacement ACP trainees will be subject to further HEE approval and availability of any new funding and educational fees
* We have discussed the reasons for leaving with the ACP trainee and notified the Faculty for Advanced Clinical Practice/Primary Care Workforce and Training Hub (PCWTH) (through completion of this form)
* We have agreed that the ACP trainee will be leaving our employment as detailed above

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| --- | --- | --- | --- |
| **Signed &**  **position** |  | **Date** |  |

1. **New employer (including employing GP Practice)**

We confirm that:

* We are fully aware of the commitment and support required to employ an ACP trainee and have connected with the Faculty for Advanced Clinical Practice and/ or PCWTH. As a result of this we have been made aware of associated application and approval processes (via the training environment site visit to the new employer/telephone call between the Faculty/PCWTH and the new employer)
* We acknowledge training grant and educational fees may not automatically transfer from ACP trainee’s previous employer and is subject to HEE approval using the agreed process
* The ACP trainee is expected to start with us on the start date shown on page 1 of this document

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| --- | --- | --- | --- |
| **Signed &**  **Position** |  | **Date** |  |

**BY COMPLETING THIS FORM, I UNDERSTAND THAT THE FACULTY, HEI, EMPLOYERS AND SUPERVISORS WILL USE MY INFORMATION IN LINE WITH GDPR GUIDANCE**