**Please complete Form electronically**

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| 1. **Applicant Personal Details:** | | | | | | | | | | | | | | | | |
| **Surname:** | |  | | | | **First Name:** | | | | | |  | | | | |
| **Job Title:** | |  | | | | **GMC, NMC PIN or Professional Body Number:** | | | | | |  | | | | |
| **Place of Work Name:** | |  | | | | **Practice Code:** | | | | | |  | | | | |
| **Email Address:** | |  | | | | **Place of Work Contact Telephone Number:** | | | | | |  | | | | |
| 1. **Event Details:** | | | | | | | | | | | | | | | | |
| **Event Title:** | | Health Coaching in Pain Management (Two-half day Course) | | | | **Event Deadline Date:** | | | | | | Wednesday 9 February 2022 | | | | |
| **Event Date:** | | Day 1: **Wednesday, 2 March 2022**  Day 2: **Wednesday, 16 March 2022** | | | | | | | | | | | | | | |
| **Event Timings:** | | **Start Time:** | | 1300Hrs | | | | | | **End Time:** | | | | 1630Hrs | | |
| **Course Provider:** | | Peak Health Coaching | | | | **Course Facilitator:** | | | | Dr. Tim Williams | | | | | | |
| **Course Delivery Method:** | | Virtual Attendance | | | | **Cost to Practice to Attend Event:** | | | | FREE - The Staffordshire Training Hub have secured regional funding to subsidise this course (which costs £250.00 per person) | | | | | | |
| 1. **Equality Monitoring Questionnaire:** | | | | | | | | | | | | | | | | |
| * The Staffordshire Training Hub is collecting the following information to ensure the training and educational services we provide to the Primary Care workforce in Staffordshire is being accessed equitably. It will also help us to identify and better understand the profile and diversity of the workforce. * Please be assured that any information you do provide to the Staffordshire Training Hub will be kept completely confidential. * No identifiable information provided will be shared with other bodies, members of the public or press. * **Completion of Part 3 is voluntary, if you do not wish to complete fully or answer any of the question(s), this will not affect your application in any way, and move onto Part 4 of the Application Form.** | | | | | | | | | | | | | | | | |
| **What is your gender?** | | |  | | | | | | **Which age group applies to you?** | | | | | |  | |
| **Which of the following best describes your sexual orientation?** | | |  | | | | | | | | | | | |  | |
| **What is your religion or belief?** | | |  | | | | | | | | | | | |  | |
| **What is your ethnic group?** This is about the ethnic group which you feel you belong. If you feel you belong to more than one ethnic group, please choose the one you feel you most belong to. | | | | |  | | | | | | | | | |  | |
| **Are you a disabled person as defined by the Equality Act 2021?** The Equality Act 2021 defines a disabled person as “someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities”. | | | | | | | | | | | | | | |  | |
| **If you answered yes to the question above, please tick all that apply:** | | | Long-term illness/Health Condition  Learning Disability/Difficulty  Mental Health Condition  Physical Impairment  Sensory Impairment  Other – please state: | | | | | | | | | | | | | |
| **Do you have caring responsibilities for any children or adults?** | | | | | | | | |  | | | | | | | |
| **If you answered Yes to the question above, please tick which apply:** | | | Child(ren)  Adult(s) | | | | **If Yes, are you a registered Carer?** | | | | | |  | | | |
| **We appreciate and thank you for taking the time to complete Part 3. If you have any questions or wish to submit any feedback, please do not hesitate to contact the Staffordshire Training Hub at** [**TrainingHub@GPFirst.net**](mailto:TrainingHub@GPFirst.net) | | | | | | | | | | | | | | | | |
| 1. **Applicant Declaration** | | | | | | | | | | | | | | | | |
| 1. I confirm that I am fully committed to the above event, and it is appropriate to support and enhance my learning. 2. I will submit an electronically completed Application Form to my Practice for declaration of support. 3. I am aware that confirmation of place will only be sent by the Staffordshire Training Hub Team. 4. The Staffordshire Training Hub will include you on our Mailing List if you wish to opt out, please check this box | | | | | | | | | | | | | | | | |
| **I have fully completed the Application Form and I will submit to my Practice Manager or Clinical Lead for approval:** | | | | | | | |  | | | | | | **Date:** | |  |
| 1. **Practice Manager or Clinical Lead Approval:** | | | | | | | | | | | | | | | | |
| 1. I confirm that I have discussed this training request with the above named, and it meets the above objective in their Personal Development/Training Plan 2. I can confirm the Practitioner’s absence is sustainable from clinical activity, and that the Practice will support the applicant with time to attend/undertake the training event. 3. If the delegate is unable to attend, I will e-mail STH, so that the place can be offered to another colleague. 4. **Unless exceptional circumstances prevail, I understand, if less than 48 hours’ notice is given to cancel a place, the Practice will pay the Staffordshire Training Hub £50 for each cancelled date towards the cost of the training event (maximum £100 for two dates).** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Full Name:** |  | | | | | **Job Title:** | | | | |  | | | | | |
| **Email Address:** |  | | | | | **Date:** | | | | |  | | | | | |
| **Action Required:** | Please kindly e-mail fully completed Application Form to the Staffordshire Training Hub at [arrs.traininghub@nhs.net](mailto:arrs.traininghub@nhs.net). | | | | | | | | | | | | | | | |