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Description automatically generated**Please confirm you are applying under criterion 3:**

Inter-Foundation School Transfer (IFST)

Application Form

## Criterion 3 – medical condition or disability

You have a medical condition (physical or mental health) or disability for which on-going follow up for the condition in the specified location is an absolute requirement, and your circumstances have changed since submitting your original application or commencing your foundation training.

March 2024

## Applicant statement

Please read the applicant guidance before commencing your application. Please complete this form electronically.

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| **YOUR DETAILS** | | | | |
| **Surname** | Click or tap here to enter text. | | **First name** | Click or tap here to enter text. |
| **Email address** | Click or tap here to enter text. | | **GMC number** | Click or tap here to enter text. |
| **Your current address** | Click or tap here to enter text. | | | |
| Click or tap here to enter text. | | | |
| Click or tap here to enter text. | | | |
| Click or tap here to enter text. | | | |
| **Postcode** Click or tap here to enter text. | | | |
| **Phone number** | Click or tap here to enter text. | | | |
| **Medical school** | Click or tap here to enter text. | | | |
| **Date of entry to medical school** | Click or tap to enter a date. | | **Date of graduation** | Click or tap to enter a date. |
| **Allocated/current foundation school** | Choose an item. | | | |
| **Foundation school to which you are applying to transfer** | Choose an item. | | | |
| **Group/region within the foundation school you are applying to transfer to** (if applicable. This information will help your receiving foundation school, if your application is approved, to find the most suitable available programme for you. Specific region allocations are not guaranteed.) | | | | |
| Click or tap here to enter text. | | | | |
| **Which stage of training are you at?** |  | Entering FY1 in August (you do not need to complete the “Training experience” section)  Current FY1  Current FY2 (only applicable if you are not due to complete training in July) | | |

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| **TRAINING EXPERIENCE**  If you are currently a foundation doctor, or have previously undertaken foundation training, please provide details of all posts completed as part of the Foundation Programme to date. If you need to report more than 6 posts, please use the comments box at the end of this section to provide information about further posts. | | | | | |
| **Host employer** | **Specialty** | **Grade** | **Full time or less than full time** | **Start date** | **End date** |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Choose an item. | Click or tap to enter a date. | Click or tap to enter a date. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Choose an item. | Click or tap to enter a date. | Click or tap to enter a date. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Choose an item. | Click or tap to enter a date. | Click or tap to enter a date. |

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| **REASON FOR REQUESTING A TRANSFER**  Please explain **how your circumstances have changed** since applying to/commencing the foundation programme and why you are requesting a transfer to a different foundation school. You must clearly demonstrate how you meet the criteria for a transfer, including explaining **why you need to be in the specific foundation school requested**. Please include as much detail as possible. | |
| Click or tap here to enter text. | |
| **When did your circumstances change?**  Either exact date or month/year (depending on circumstances) will be accepted. | Click or tap to enter a date.  Or enter month/year: Click or tap here to enter text. |
| **When do you ideally wish the transfer to commence?**  Unless you have exceptional circumstances, all transfers will commence at the start of the next training year. Either exact date or month/year (depending on circumstances) will be accepted. | |
| Click or tap to enter a date.  Or enter month/year: Click or tap here to enter text. | |
| **Do you wish to be considered for less than full time (LTFT) training?** | Choose an item. |

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| **SUPPORTING EVIDENCE**  Please tick to confirm that you have provided each of the following documents listed below (where applicable) in support of your application. Applications without all the required evidence will not be approved. | |
| Supporting statement [in the form on the next page] by the current medical specialist treating/managing the condition that:   * describes the current medical condition or disability * describes the nature of the on-going treatment and frequency * explains why it is essential for treatment or medical follow up to be accessed/delivered in a specific location, rather than by other treatment centres in the UK. |  |
| Proof of address in requested foundation school (see appendix 1 in the IFST applicant guidance for a list of acceptable documents). |  |

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| **DECLARATION** | |
| I confirm:   * I have explained the changes to my circumstances and how these meet the criteria. * I will email all required documentation to my foundation school before the application deadline. * The information contained within my application and the supporting documentation is correct and truthful. * I have no unresolved or outstanding cause for concern which may have been highlighted by the ARCP process. * I am not under a GMC or criminal investigation, or I have provided details of my GMC or criminal investigation by informing my current/allocated foundation school. * I understand that this information will be treated confidentially and give my permission for all the information in this application to be considered by the national IFST review panel, passed to the receiving foundation school (if my application is approved), and if necessary, to the appeals panel. * I give permission for all the information in my application to be shared with the UKFPO and relevant parties in the case of an appeal. * I give my permission for information in this application to be used in anonymised form for review and evaluation of the process and outcomes of the UKFP IFST process. * I understand that I am expected to take up any programme offered to me by the receiving school. If I decide not to take up the offered programme my IFST application will be terminated. | |
| **Signature**  Type name or insert signature photo file if available | Click or tap here to enter text.  [Or insert photo file below] |
| **Date signed** | Click or tap to enter a date. |

## Supporting statement confirming that the applicant has a medical condition or disability for which on-going follow up in the specified location is an absolute requirement

The applicant must include with their application this signed statement from someone who works in a recognised profession. The signatory must be the current medical specialist treating/managing the condition and provide a statement that:

* describes the current medical condition or disability
* describes the nature of the on-going treatment
* describes the frequency of the ongoing treatment
* explains why it is essential for treatment or medical follow-up to be accessed/delivered in a specific location, rather than by other treatment centres in the UK.

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| **APPLICANT DETAILS** | | | |
| **Surname** | Click or tap here to enter text. | **First name** | Click or tap here to enter text. |
| **Applicant’s address** | Click or tap here to enter text. | | |
| Click or tap here to enter text. | | |
| Click or tap here to enter text. | | |
| Click or tap here to enter text. | | |
| **Postcode** Click or tap here to enter text. | | |

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| **MEDICAL CONDITION OR DISABILITY**  Please provide brief details of the current medical condition or disability |
| Click or tap here to enter text. |
| **ONGOING TREATMENT**  Please describe the nature of the ongoing treatment and frequency of follow up required |
| Click or tap here to enter text. |
| **REQUIREMENT FOR LOCAL FOLLOW UP**  Please indicate where the follow up will be delivered, by whom and why this must be delivered in a specific location, rather than by other treatment centres in the UK |
| Click or tap here to enter text. |

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| **DETAILS OF SUPPORTING SIGNATORY** | | | | | | |
| **Surname** | Click or tap here to enter text. | | **First name** | | Click or tap here to enter text. | |
| **Professional status** | Click or tap here to enter text. | | | | | |
| **Professional relationship to applicant** | Click or tap here to enter text. | | | | | |
| **Address** | Click or tap here to enter text. | | | | | |
| Click or tap here to enter text. | | | | | |
| Click or tap here to enter text. | | | | | |
| **Postcode** Click or tap here to enter text. | | | | | |
| **Phone number**  **for queries** | Click or tap here to enter text. | | | | | |
| **Email address**  **for queries** | Click or tap here to enter text. | | | | | |
| **How long you have known the applicant** | Click or tap here to enter text. | **Years** | | Click or tap here to enter text. | | **Months** |

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| **DECLARATION by Supporting Signatory** | |
| I, the undersigned, confirm that:   * I am over 18 years old * I am not related to the applicant by birth or marriage * I am not in a personal relationship with the applicant nor live at the same address * I have reviewed the IFST application form above   I further confirm that information about the applicant named above is correct and I certify that the applicant has a medical condition/disability that required follow up in the specific location requested. As such, I support the applicant’s request for consideration for an inter-foundation school transfer on the grounds of Criterion 3. | |
| **Signature**  Type name or insert signature photo file if available | Click or tap here to enter text.  [Or insert photo file below] |
| **Date signed** | Click or tap to enter a date. |

**Applicants are advised to check that all sections have been completed, and then submit the fully completed application form and any supporting documents to their foundation school*.***