**REGISTRATION FOR StR TRAINING IN OCCUPATIONAL MEDICINE**

**(FORM M1)**

This application form must be completed in full (in capitals and black ink) and returned to the Faculty of Occupational Medicine at the address to the right within one month of notification of your national training number (NTN) from your Postgraduate Deanery. A copy of that notification must accompany your application.

### APPLICANT DETAILS

|  |  |
| --- | --- |
| **Title:** | **Honours:** |
| **Surname:** | **Date of Birth:** |
| **Forenames:** | **Gender:** |
| **Business Address:**  Position/job title:  Company: | **Home Address:**  (if different) |
| **Tel:**  **Fax:** | **Tel:**  **Fax:** |
| **Mobile:** | **Mobile:** |
| **E-mail:** | **E-mail:** |
| **Preferred mailing address\*: Business / Home** (\*Delete as appropriate) | |
| **Preferred e-mail address\*: Business / Home** (\*Delete as appropriate) | |

|  |
| --- |
| **Date of full GMC Registration:** |
| **GMC Registration Number:** |
| **National Training Number (NTN):** |

**DEGREES & DIPLOMAS**

|  |
| --- |
| **Title of qualification:** |
| **Date of award:** |
| **Issuing Body:** |

**StR TRAINING POST**

|  |
| --- |
| **Name of Hospital/organisation:** |
| **GMC Training Programme Code:** |
| **Name of Educational Supervisor/Trainer:** |
| **Date of entry to specialty training:** |
| **Full–time or LTFT training (% if LTFT):** |
| **Are you training towards CCT or CESR(CP)?** |

**LIST OF POSTS HELD SINCE PRIMARY MEDICAL QUALIFICATION (Including all SHO rotations, GP work & present StR post)**

| **Title & Specialty of post**  **(i.e. SHO in A & E etc)** | **Name of Hospital/**  **Organisation** | **Supervising Consultants/**  **Trainers** | **Brief account of duties** | **Dates held**  **(Mth/Yr)** | **FOM Code**  **(StR posts only**) | **Office use only**  **Comments** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

**COURSES**

|  |  |  |
| --- | --- | --- |
| **Course Title & Institution** | **Date & Length of Course** | **Full or Part Time** |
|  |  |  |

### I hereby apply to register with the Faculty for StR training in Occupational Medicine and to be admitted to the Faculty as a Specialty Registrar member.

### I declare that the information provided is complete and accurate and agree to pay annual membership fees due in April each year until such time as I tender my resignation in writing or am admitted as an Associate or Member.

### I understand that failure to pay membership fees in a timely manner may jeopardise my training status and may lead to a delay in the process leading to the award of my CCT.

### I understand that the personal data provided on this form will be used in accordance with the Faculty’s registration under the Data Protection Act 1998. I agree that the Faculty can pass information from this form and any other information relating to my training and my compliance with the Faculty’s Articles of Association and Regulations to relevant regulatory bodies and to relevant deaneries, but will not pass any personal information to external commercial organisations.

### SPECIALTY REGISTRARS’ FORM OF FAITH

### I hereby faithfully promise to abide by the Standing Orders\* of the Faculty and the Bye-Laws, Statutes and Regulations of the Royal College of Physicians as they apply to Specialty Registrars of the Faculty of Occupational Medicine.

### Signature…………………………………………...…… Date………………………….

\* current version available on the Faculty website at [www.fom.ac.uk](http://www.fom.ac.uk)

|  |
| --- |
| Declaration by Supervisor:  I agree to supervise the training of this candidate in accordance with the Faculty regulations. I believe that the details given on the registration form are correct.  SIGNATURE OF SUPERVISOR: ……………………………….. Date:…………………….  Name & Address of Supervisor: |

### PAYMENT FORM

**For registrations effective between 1 April 2016– 31 March 2017**

*Please complete and return with payment if appropriate.*

The Faculty’s subscription year runs from the 1st April to 31st March and you are required to subscribe as a trainee with effect from the month in which you register with the Faculty. Indicate with a tick in the grey box the relevant subscription period and include the appropriate amount in the total with the registration fee.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Payment is for: | | | | | | | Amount: |
| 4350 | Registration fee for StR training | | | | | | £209.00 |
|  | Subscription rates (includes the monthly publication *Occupational & Environmental Medicine)* | | | | | |  |
|  | From Apr 16 |  | £340.00 | From Oct 16 |  | £170.00 |  |
|  | From May 16 |  | £311.67 | From Nov 16 |  | £141.67 |  |
|  | From Jun 16 |  | £283.33 | From Dec 16 |  | £113.33 |  |
|  | From Jul 16 |  | £255.00 | From Jan 17 |  | £85.00 |  |
|  | From Aug 16 |  | £226.67 | From Feb 17 |  | £56.67 |  |
|  | From Sep 16 |  | £198.33 | From Mar 17 |  | £28.33 |  |
|  |  | | | | | **TOTAL:** |  |

I will make payment directly to the Faculty’s bank account - *please see FOM bank details below*

I will pay by credit/debit card – *please contact John Rafferty on 0203 116 6905.. We are unable to accept**American Express or Diners Club cards*.

**The Faculty strongly advises against sending cheques due to risk of postal fraud**

|  |  |
| --- | --- |
| Name of purchaser\* *(please print)* |  |
| Cardholder address\*: |  |
| Postcode\* |  |
| Daytime telephone number |  |
| Email address |  |

Signature ……………………………………… Date …………………………………………

**Please ensure you quote your candidate No./surname as the reference when paying by BACS**

**Paying by BACS:**

Account name: Faculty of Occupational Medicine

Sort Code: 30-93-68

Account number: 17715068

BIC code: LOYDGB 21028

IBAN: GB91 LOYD 3093 6817 7150 68

**Equality and diversity monitoring**

The Faculty of Occupational Medicine is an equal opportunities organisation committed to ensuring that no applicant receives less favourable treatment than others on grounds of, age, disability, gender reassignment, marital/partnership status, pregnancy and maternity, race, religion/belief, sex or sexual orientation, gender reassignment or marital/civil partnership status.

Monitoring is strictly confidential but not anonymous. Data provided on this form will be used only in accordance with the Faculty’s data protection registration.

You are asked to provide responses about protected personal characteristics below. Your responses are VOLUNTARY and you may give a ‘decline to answer’ response.

A British Medical Association (BMA) report on equality and diversity in examinations is at the following link:

<http://bma.org.uk/about-the-bma/equality-and-diversity/royal-college-exams>

|  |  |  |  |
| --- | --- | --- | --- |
| **Protected characteristic** | **Answer** | | **Decline to answer** |
| **Date of birth (dd/mm/yy)** |  | |  |
| **Do you consider yourself to have a disability or long-term health condition** | Yes/No | |  |
| **Are you proposing to undergo/ undergoing or have you undergone gender reassignment** | Yes/No | |  |
| **Marital/partnership status** | **Please tick the appropriate box below:** | | |
| Single |  |  |
| Married |  |
| Civil partnership |  |
| Divorced |  |
| Civil partnership dissolved |  |
| Widow |  |
| Widower |  |
| Surviving civil partner |  |
| Separated |  |
| **Are you pregnant or have you given birth within the last 26 weeks** | Yes/No | | |
| **Race** | **Choose ONE section from A to E and then tick the appropriate box** | | |
| **A: Asian or Asian British** | Bangladeshi |  |  |
| Indian |  |
| Pakistani |  |
| Other Asian background  (please state) |  |
| **B: Black or Black British** | African |  |
| Caribbean |  |
| Other Black background  (please state) |  |
| **C: Chinese or other ethnic group** | Chinese |  |
| Other (please state) |  |
| **D: Mixed Heritage** | White and Asian |  |
| White and Black African |  |
| White and Black Caribbean |  |
| Other Mixed background  (please state) |  |
| **E: White** | British |  |
| English |  |
| Irish |  |
| Scottish |  |
| Welsh |  |
| Other White background  (please state) |  |
| **Religion/belief** | **Please tick the appropriate box below:** | | |
| Atheism |  |  |
| Buddhism |  |
| Christianity |  |
| Hinduism |  |
| Islam |  |
| Judaism |  |
| Sikhism |  |
| Other (please state) |  |
| **Sex** | Male/Female | |  |
| **My sexual orientation is:** | **Please tick the appropriate box below:** | | |
|  | Bisexual |  |  |
|  | Gay man |  |
|  | Gay woman/lesbian |  |
|  | Heterosexual/Straight Other |  |
| **Date:** |  | |  |