**Designated Medical Practitioner Form**

When this form has been completed and signed by your designated medical practitioner, please scan it and upload it to your application form.

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| **For completion by the Designated Medical Practitioner** | **Please complete sections below** |
| Name |  |
| Qualifications |  |
| GMC number |  |
| Email address |  |
| Contact telephone number |  |
| Contact address |  |
| **In order to confirm that the DMP meets the criteria for supervising the period of learning in practice within this programme, please confirm you are a registered medical practitioner who:** | **Tick boxes below to confirm** |
| Has had at least 3 years medical responsibility for a group of patients in the relevant field of practice  |  |
| Is working as a GP OR a specialist registrar, clinical assistant or consultant with an NHS trustHas the support of the employing organisation or GP practice to act as the DMP |  |
| Has experience or training in teaching and/or training supervision in practice |  |
| I confirm that I have agreed to supervise [name] during the period of learning I practice for the programme. I agree to provide supervision, support and shadowing opportunities and am familiar with the requirement of the programme. | **Signature and Date** |