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.

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 trust Has 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 90-hour period of learning I practice for the programme. I agree to provide supervision, support and shadowing opportunities, and assessment in practice and am familiar with the requirements of the programme.	Signature and Date