ADVANCED TRAINING SKILLS MODULE (ATSM)
REGISTRATION FORM

Please insert name of ATSM module below:

____

____

Work Intensity Score: _______

Please note there is a maximum work intensity score of 3.0 per trainee. Please list the other ATSMs you **are already registered** for:

Name of ATSM: ____ Work Intensity Score:___

Name of ATSM: ____ Work Intensity Score:___

SURNAME: ____

FIRST NAMES: ____

RCOG REG NO: ______________________________

NTN-Holders only:

NTN (National Trainee Number): __ __ __/__ __ __/__ __ __/__

Projected CCT date: __ __/__ __/__ __

NTN-Holders and LATs (SY6/7 equivalent) only:

Year of training SpR: ____ or ST: _____ or LAT: ______

Non - Training Grades only: Type of Post:____

ENTRY CRITERIA: **(you must have possession of the MRCOG)**

Date MRCOG Part 2 obtained: __ __/__ __/__ __

Please complete overleaf

NAME AND ADDRESS OF DEANERY OF ATSM TRAINING:

____

____

____

NAME AND ADDRESS OF HOSPITAL/TRAINING CENTRE:

____

____

____

DATE OF COMMENCEMENT OF ATSM: __ __/__ __/__ __

Applicant Signature: ___________________________________ **Date:** ______________

TO BE COMPLETED BY ATSM EDUCATIONAL SUPERVISOR(S)

NAME OF EDUCATIONAL SUPERVISOR(S) IN CHARGE OF TRAINING:

1. Print NAME: ________________________ **2. Print NAME:** ____________________

________________________________ ______________________________

POST:______________________________ **POST:**___________________________

DEPARTMENT ADDRESS: **DEPARTMENT ADDRESS:**

____________________________________ _________________________________

____________________________________ _________________________________

____________________________________ _________________________________

I agree to provide the training necessary for the completion of this ATSM

Supervisor Signature (1): _______________________________ **Date**: _____________

Supervisor Signature (2): _______________________________ **Date:**_____________

Please complete overleaf

TO BE COMPLETED BY THE ATSM PRECEPTOR

Name (printed):____

Signature: ____

Date:________________________________

TO BE COMPLETED BY THE DIRECTOR OF ATSMs ON BEHALF OF THE DEANERY SPECIALTY TRAINING COMMITTEE/POSTGRADUATE SCHOOL

I confirm that the above applicant has completed intermediate training and that the Deanery Specialty Training Committee/Postgraduate School has approved the training module for the applicant, Educational Supervisor(s) and programme of training.

Name (printed):____

Signature:____

Date:________________________________

FOR NON TRAINING GRADES THIS SECTION ALSO NEEDS TO BE COMPLETED BY CLINICAL DIRECTOR

I confirm that I agree for the applicant to register for the above ATSM.

Name (printed): ____

Signature: ____

Name of Hospital: _______________________________________

Date: ____

IT IS THE RESPONSIBILITY OF THE APPLICANT TO OBTAIN THE REQUIRED SIGNATURES AND SUBMIT WITH THE REGISTRATION FEE OF £133 TO EDUCATION POLICY AND QUALITY AT THE COLLEGE. CHEQUES SHOULD BE MADE PAYABLE TO THE RCOG.

Please return to:
Trainees' Coordinator, Education Policy and Quality, RCOG, 27 Sussex Place, Regent's Park, London NW1 4RG