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 **Fundamental Applications of Computed Tomography**

**Application Form**

**Section One**

**Applicant name:**

**Employing organisation name:**

Please ensure you have completed and included the following sections:

[ ]  Section One – Declaration

[ ]  Section Two – Module requirements

[ ]  Section Three – Clinical supervisor confirmation

**Declaration**

I confirm that the information contained within this application is accurate. I understand that:

* I will not be accepted onto the course until the application form and any other required paperwork is uploaded to the CPD portal.

You can log in to the CPD portal to check the status of your application, or to upload additional paperwork, by clicking on this link <https://mycpd.uwe.ac.uk/users/sign_in>

|  |  |
| --- | --- |
| Signature of Student: (E-signature accepted)  | Date:  |

**Section Two**

**I confirm that I meet the following requirements for admission to the Injection Therapy CPD Module as stated below:**

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| [ ]  I am registered with a recognised professional / regulatory body e.g. HCPC, NMC, GMCProfessional registration number:  |
| [ ]  At least 50% of my clinical time is dedicated to CT imaging.Please provide details of your job role and your current area of practice: |
| [ ]  I have appropriate computer skills e.g. able to attach documents to e-mails, familiar with Word etc. |
| [ ]  I have a designated clinical educator in place. |

**Section Three – For Clinical Educator to complete**

**As the clinical educator I can confirm that:**

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| * The applicant has the relevant experience and is currently working in a CT role for at least 50% of their clinical time
 |
| * I am registered with the HCPC / a recognised professional body. Please state which professional body:
 |
| * I have relevant clinical experience of Computed Tomography (4 years Clinical Practice)
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| * I am able to devote sufficient time to support the student in achieving the amount of supervised learning required (includes case discussion observation of practice and feedback.
 |
| * I have experience or training in supervision in practice.
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**Clinical Educator**

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| Name (please print as shown on professional register):  |
| Email address **(Please print):**  |
|  |
|  |
| Professional registration number:  | [ ]  Checked by UWE |
| Signature: (Scanned wet signature please) | Date:  |