Northern School of Anaesthesia

& Intensive Care Medicine

***Educational Supervision – Return to work form and Review of return to work form***

***(initial meeting to take place 6-8 weeks prior to returning to work and return to work review 1-3 weeks after return to work in conjunction with initial educational supervision meeting)***

### **Trainee Information**

|  |  |
| --- | --- |
| **Registered Name** |  |
| **GMC Number** |  |
| **Postal address** |  |
| **E-mail address** |  |
| **College Ref Number** |  |
| **Training Number** |  |
| **Year Qualified** **(Primary Medical Degree)** |  |
| **Year of Training** |  |
| **Date entered current Training Year** |  |
| **Date entering next Training Year** |  |
| **Estimated CCT Date** |  |
| **Date of last ARCP** |  |

**Educational Supervision**

|  |  |
| --- | --- |
| **Educational Supervisor** |  |
| **ES e-mail address** |  |

### **Attachment**

|  |  |
| --- | --- |
| **Current Placement / Training Unit** |  |
| **Start Date** |  |
| **End Date** |  |

**Returning to work information**

|  |  |
| --- | --- |
| **Hospital prior to absence** |  |
| **Date leave commenced** |  |
| **Hospital where returning** |  |
| **Date of return** |  |
| **Reason for absence from work** |  |
| **Duration of absence** |  |
| **Returning full time (FT) or less than full time (LTFT)?** |  |
| **Which modules do you need to complete?** |  |
| **Do you have any type of disability?****Do you have any health issues that may affect returning to work?****If ‘yes’ to above – are occupational health involved?** |  |
| **Is the rota maker aware of your working arrangements?** |  |
| **Have you undertaken any CPD whilst absent from work?** |  |
| **Are you doing any ‘keeping in touch days’?** |  |
| **Any particular concerns over returning to work?** |  |

**Meeting 1: Return to work planning**

**Suggested discussion:**

|  |  |
| --- | --- |
| **Todays date:** |  |
| **Do you feel you would benefit from/need to undertake a supervised return to work period?****(*1 week is recommended if returning full time and 2 weeks if returning LTFT)*** |  |
| **When will you return to the out of hours rota?** |  |
| **At this stage can you identify any particular learning needs?** |  |
| **How will induction be undertaken?** |  |
| **Additional comments**  |  |
| **Date for review meeting (1-3 weeks after returning to work)** |  |

**Signed:**

**Trainee Educational Supervisor**

**Meeting 2: Return to work review**

**Suggested discussion:**

|  |  |
| --- | --- |
| **Todays date** |  |
| **Overall progress** |  |
| **Has your initial return to work highlighted any particular learning needs?** |  |
| **Additional comments** |  |
| **Do you wish to have another meeting prior to the intermediate educational supervision meeting?** |  |

**Signed:**

**Trainee Educational Supervisor**

Instructions:

Please keep this form locally and give the trainee a file copy.

The trainee should upload the document into their e-Portfolio library and associate it to the correct level of training e.g. Basic Level Training. It does not need associating with individual modules.***In the library it should be given the title Initial ES Meeting <Hospital><Date>***

If you keep paper copies it is suggested that it is signed above. Please keep an electronic copy which we will request from time to time in a batch from your College Tutor or departmental secretary. Please be sure to keep a backup copy and to keep all these confidential.

Please name the file as follows:

<Trainee GMC number plus date of meeting as YYYY/MM/DD.doc> and save it as MS Word file, ideally Word 97.

Thus a file for a meeting with a doctor whose GMC number is 2433857 on June 1st 2007 should be saved as:***243385720070601.doc***

Additions to this information, as needed locally or because of trainee’s needs or aims are welcome, but please do not remove items, and make additions at the end of each section.