**Application for Workforce Development Funding (WDF)**

Please note that this application is only for the funding of a course and is subject to further acceptance by the course provider. All applications will be reviewed by Lincolnshire Training Hub and our relevant wider system partners and course provider. Information will be stored and shared in line with GDPR.

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| **Applicants Details** |
| Name of Applicant |  |
| Applicants Role |  |
| Time Since Qualification |  |
| Time Working in General Practice |  |
| Time in Current Role |  |
| Home Address  |  |
| Email Address |  |
| Personal Contact Number |  |
| Have you previously received funding for training? If so, what for and when? |  |

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| **Practice Details** |
| Practice Name |  |
| Practice Address |  |
| Practice Telephone |  |
| Practice Manager |  |
| Partners Details  |  |
| Primary Care Network |  |

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| **Course Details** |
| Course Title |  |
| Course Provider |  |
| Course Duration |  |
| Course Cost inc VAT | £ |

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| **Personal Statement** approx. 300 words |
| *Why do you want to complete the course**What is the benefit to the practice**What is the benefit to the patient* *What benefit is the course to the Primary Care Networks (PCNs)* |

**Declaration of Commitment**

In submitting this application for funding I confirm my commitment to the requested course and that my practice supports my training. I confirm that:

My practice will nominate a designated supervisor, to be responsible for the provision of all required support and to be reasonably available throughout my training.

This named person is (INSERT NAME) \_\_\_\_\_\_\_\_\_­­­­\_\_\_\_

My practice will release me to attend the study days and any other educational commitments (e.g. exams, reflective learning sessions etc.) throughout the duration of the programme.

My practice will ensure the provision of designated learning time throughout the duration of the programme.

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|  | **Name** | **Signature** | **Date** |
| Applicant |  |  |  |
| Practice Manager |  |  |  |
| Partner |  |  |  |