**Medical Terminology Application Form**

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.

|  |  |
| --- | --- |
| **Applicant’s Details** | |
| Name of Applicant |  |
| Applicant’s Role |  |
| 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? |  |

|  |  |
| --- | --- |
| **Practice Details** | |
| Practice Name |  |
| Practice Address |  |
| Practice Telephone |  |
| Practice Manager |  |
| Partners’ Details |  |
|  |  |

|  |
| --- |
| **Personal Statement** approx. 150 words |
| *Why do you want to complete the course?*  *What is the benefit to the practice?* |

**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 release me to attend the course.

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