Dartford and Gravesham NHS
NHS Trust

APPLICATION FOR TASTERS

To be submitted at **least six weeks** prior to educational activity.

Full Name:	

Email:		**Contact telephone/bleep:**	

Current speciality:	

Training Programme:	

Educational Supervisors name	

TASTER DETAILS	
Specialty:	
Location:	
Taster Supervisors Name:	

Dates of proposed leave	**From:**	**To:**	**No of days:**

YOU *MUST* ARRANGE COVER FOR YOUR CLINICAL COMMITMENTS PRIOR TO SUBMITTING THE FORM. *LOCUMS CANNOT BE ARRANGED.*

Commitments to be covered (please specify): If internal cover required, who has agreed to cover you?

Objectives of the 'Taster Experience:
1. **2.** **3.**

Proposed Clinical Timetable for your Taster Session:					
Day	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM					
PM					

APPROVALS	
Rota Manager's signature:	
Date:	

Educational Supervisor name/Signature: ***(Educational confirmation)***	
Date:	

Taster Supervisor name/Signature: ***(Educational confirmation)***	
Date:	

I confirm that this application for a 'taster' experience has been approved and the number of days should be subtracted from this trainees study leave allocation.	
Foundation Programme Director: ***(Educational confirmation)***	
Date:	

Applicant Signature:	
Print name:	
Date:	

PLEASE SUBMIT YOUR COMPLETED APPLICATION FORM TO THE MEDICAL EDUCATION DEPARTMENT FOR PROCESSING.

Director of Medical Education name/signature:	
Print name:	
Date:	