**NHS England - North West**

**Withdrawal of Time Out of Programme Application/**

**Curtailment of Time Out of Programme**

|  |  |  |  |  |  |
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| **SECTION 1: PERSONAL DETAILS (to be completed by resident doctor)** | | | | | |
| Surname |  | | First Name |  | |
| Specialty |  | | Contact Email |  | |
| Training Number | |  | GMC Number |  | |
| Type of OOP | | OOP**T** | Start date of OOP  (currently approved) | |  |
| OOP**R** |
| OOP**E** | End date of OOP  (currently approved) | |  |
| OOP**C** |
| OOP**P** |

|  |  |  |
| --- | --- | --- |
| **SECTION 2: WITHDRAWAL/CURTAILMENT OF OOP (to be completed by resident doctor)** | | |
| I wish to withdraw my OOP application and remain in the training programme | |  |
| I wish to curtail my time OOP and return to the training programme | |  |
| Proposed return to training date (curtailment only) | |  |
| Reason for withdrawal/curtailment |  | |
| Signature of Trainee |  | |

|  |  |  |
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| **SECTION 3: SECTION TO BE COMPLETED BY TRAINING PROGRAMME DIRECTOR** | | |
| I confirm I am in support of the above request (if not, please detail reasons below) | |  |
| Name of Training Programme Director |  | |
| Signature of Training Programme Director |  | |
| Reason(s) for non-approval |  | |

|  |  |  |
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| **SECTION 4: SECTION TO BE COMPLETED BY ASSOCIATE DEAN** | | |
| I confirm I am in support of the above request (if not, please detail reasons below) | |  |
| Name of Associate Dean |  | |
| Signature of Associate Dean |  | |
| Reason(s) for non-approval |  | |

**NB: It is the resident doctor’s responsibility to ensure completion of sections 1-3 before submitting the form to the appropriate Programme Support Manager**