

**Application Form for participants**

**Oncology (cascaded) clinical training application form**

**(acute cancer presentation triage and management of urgent cancer symptoms)**

**Location: Bomah Hotel, Gulu, Uganda**

**Dates: 2-5 December 2019**

**Scan and return by email to: caroline.kiconco@britishcouncil.or.ug**

**Deadline: Wednesday 20 November 2019**

Applicants must fulfill *all* of the following criteria:

* Hold a Bachelor of Medicine, Bachelor of Surgery (MBChB)
* Be a Medical Officer or Medical Officer Special Grade (MOSG)
* Be based in the Northern Regions of Uganda (ABIM; ADJUMANI; AGAGO; ALEBTONG; AMOLATAR; AMUDAT; AMURU; APAC; ARUA; DOKOLO; GULU; KAABONG; KITGUM; KOBOKO; KOLE; KOTIDO; LAMWO; LIRA; MARACHA; MOYO; NAKAPIRIPIRIT; NAPAK; NEBBI; NWOYA; OTUKE; OYAM; PADER; YUMBE; ZOMBO
* **Note:** Trainees will need to confirm that leave-off-duty has been warranted by the necessary authority.

*The information that you provide may be used in the compilation of data and reports, but the source will be kept anonymous. Please type or complete legibly in BLOCK CAPITALS. Use additional blank pages if necessary.*

**Personal details**

|  |  |  |
| --- | --- | --- |
| Last name / Family Name |  | |
| Forename(s)/First Name(s) |  | |
| Date of Birth |  | |
| Gender |  | |
| Correspondence address | Contact telephone number (with country code) | |
|  | | Fax number (with country code) |
| Email Address |
|  |

**Qualification details**

|  |  |
| --- | --- |
| Name and address of University/Medical School for your primary medical qualification: | Title of Qualification: |
| Date started (dd/mm/yy): |
| Date finished (dd/mm/yy): |
|  |

**Employment history: current post**

|  |  |
| --- | --- |
| Name and address of employing hospital/institution: | Job Title & grade: |
| Date started |
|  |
| Specialty interest: | |

**Employment history: previous appointments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please list your past medical appointments. You should enter all dates in full and use additional blank sheets if necessary. | | | | |
| From  mm/yy | To  mm/yy | Grade | Specialty | Hospital |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| What are your objectives for this programme?  In other words, what do you want to get out of it? |

|  |
| --- |
| What impact would you hope that such a programme will have on your healthcare provision? |

|  |
| --- |
| Do you have suitable internet access to follow up possible post-workshop on-line activities? |

**Signature**

|  |
| --- |
| I confirm that the information I have provided in my application is correct and true. I understand that any false declaration in any part of the application may result in a refusal of the application. I understand that the British Council and the Royal College of Physicians reserve the right to refuse my application, or request further documentation and evidence to support my application if they feel it is necessary. I understand that the British Council and Royal College of Physicians retain the right to withdraw the offer of a place in the training if any information provided in my application is found to be false or misleading at a later date. I consent to the British Council and Royal College of Physicians processing and retaining the personal information contained in this application in accordance with the General Data Protection Regulation 2016 and the UK Data Protection Act 2018.  Signature\* Date |

\* Electronic signatures are acceptable, as well as typing your name on the signature space.