

**Professional Development Certificate in Travel Medicine**

APPLICATION FORM

**To be completed by the APPLICANT**

Please note, email and internet access are required for these courses

|  |
| --- |
| **SECTION 1 APPLICATION DETAILS**  |
| Please complete this form for the part-time online distance learning Professional Development Certificate in Travel Medicine course. |
| Ref No*(Official use only)*:        |
| Where did you hear about this course?       |

|  |
| --- |
| **SECTION 2 PERSONAL DETAILS** |
| Title:       |  |
| Family Name:       |
| Forename(s):       |
| **SPECIAL REQUIREMENTS**It is the responsibility of the applicant to notify the College of any educational adjustments they required when submit this application.Do you require any educational adjustments for undertaking this course? [ ]  Yes [ ]  No  | If yes, applicants requesting educational adjustments must be supported by evidence. Do you currently have an Educational Support Plan or Assessment Report from an educational psychologist? [ ]  Yes [ ]  No You will be required to provide the relevant information and documents to support any educational adjustments required. e.g. a current Dyslexia Assessment Report.   |
| Do you consider English as your first language? [ ]  Yes [ ]  No  | If no, do you have an English language certificate? [ ]  Yes [ ]  No   |
| Please state which of the following English language certificates you have: | TEFL [ ]  IELTS [ ]  None [ ]  Other [ ]  If other, please specifyYou must provide a copy of you certificate along with your application. |
| Please confirm that you have suitable information technology (IT) and the relevant IT skill to complete this course? [ ]  Yes [ ]  No  |

|  |
| --- |
| **SECTION 3 CONTACT DETAILS** |
| **HOME**  |
| Address:       |
|  |
| Postcode/zip:       |
| Country:       |
| Telephone/Mobile:       |
| E-mail:       |
| Fax:       |
| Please confirm your preferred method of contact:  Phone: [ ]  E-mail: [ ]  Letter: [ ]  |

|  |
| --- |
| **SECTION 4 QUALIFICATIONS, PROFESSION AND REGULATORY BODY** |
| Please provide your professional qualification(s), your current profession and name of your regulatory body.  |
| **Name of awarding institution/college** | **Dates attended** | **Degree/Diploma** | **Main subjects** |
|  |  |  |  |
| Profession:       | Regulatory Body:      |

|  |
| --- |
| **SECTION 5 CURRENT EMPLOYMENT** |
| Job title:       | Date of commencement:        |
| Employer’s name:       |
| Employer’s address:       |
| Email:       | Telephone:       Fax:       |
| Please provide a brief description of your main responsibilities (include any information relevant to travel medicine):

|  |
| --- |
|  |

  |

|  |
| --- |
| **SECTION 6 PERSONAL STATEMENT AND COURSE BENEFITS TO YOU** |
| Please indicate why you want to undertake this course and how you think it may benefit you in the future:

|  |
| --- |
|  |

  |

|  |
| --- |
| **SECTION 7 FINANCE** |
| Please indicate how you intend to fund this course: (Tick as appropriate) Self-funding [ ]  Company paying [ ]  Other [ ]  If other, please specify:      Please indicate below, your preferred method of payment:  Bank draft [ ]  Cheque [ ]  Credit/debit card [ ]  Bank Transfer [ ]   |

|  |
| --- |
| **SECTION 8 REFERENCE - PLEASE PROVIDE THE DETAILS FOR ONE REFEREE** |
| **Your referee must describe your suitability for this programme**  |
| Reference Type: Employer [ ]  Professional [ ]  Personal [ ]  |
| How long have you known this person?       |
| Name:       |
| Profession:       |
| Address:       |
|  |
| Postcode/zip:       |
| Telephone:       |
| E-mail:       |
| Please forward the reference form to your referee and request completion at their earliest convenience. This form MUST be returned to you in PDF format and submitted with your application form and e-mailed to: karen.ross@rcpsg.ac.uk  |
| Please note, your application will not be processed until your reference has been received. |

|  |
| --- |
| **SECTION 9 CHECKLIST** |
| Failure to complete any part of this application form may delay the application process. Please ensure you have ticked all of the boxes and included all relevant information before submitting your application. Please confirm all sections of the application form are completed [ ]   |

|  |
| --- |
| **SECTION 10 DECLARATION** |
| **DECLARATION** (To be signed by ALL candidates)I confirm, to the best of my knowledge that all the information given on this form is a true statement of fact.Signature of Applicant: …………………………………………………………………………….. Date ………………………………………………. |

**Please return your completed application to:**

Professional Development Certificate in Travel Medicine Course Administrator

Royal College of Physicians and Surgeons of Glasgow, 232 - 242 St Vincent Street, Glasgow, G2 5RJ

Tel: +44 (0)141 221 6072 Fax: +44 (0)141 221 1804 e-mail: pdc@rcpsg.ac.uk [www.rcpsg.ac.uk](http://www.rcpsg.ac.uk)

Registered Charity SC000847 A Charity Registered in Scotland

All Information we hold concerning you as an individual will be held and processed by the College strictly in accordance with the provisions of the Data Protection Act 1998. Such data will be used by the College to administer its relationship with you as an affiliate. We will not, without your consent, supply your name and address to any third party except where (1) such transfer is a necessary part of the activities that we undertake, including the provision of library services (if applicable) or (2) we are required to do so by operation of law. As an individual you have a right under the Data Protection Act 1998 to obtain information from us, including a description of the data that we hold on you. Should you have any enquiries about this right please contact Membership Services Administrator at the College.

*For official use only*:

|  |
| --- |
| **SECTION 11 APPLICATION PROCESS** |

|  |  |  |
| --- | --- | --- |
| **Complete Application:** (includes reference and English certificate, if applicable). Ready for review?[ ]  Yes [ ]  No  | **Application Reviewed by:** | **Outcome of Review**:  [ ]  Yes: Process application [ ]  No: Give reason below |
| **Staff Name:**  | **Staff Name:****Staff Name:** | **Reason:**  |
| **Please state if any further action(s) required:** (e.g. Additional Support Package and/or meeting required to discuss needs). |