Please refer to College guidance on TSCs

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| --- |
| CONTACT DETAILS OF LEAD CLINICAL SUPERVISOR |

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Contact Address |  |
| Telephone No.  |  |
| Email address |  |

|  |
| --- |
| **DESCRIPTION OF PROPOSED POST** |

|  |  |
| --- | --- |
| Title/Special Interest |  |
| LETB/Deanery |  |
| Location |  |
| Name of clinical supervisor(s) |  |
| Is the post part of the LETB/Deanery’s GMC approved training programme? |  |
| Length of recognition requested for TSC  |  |
| Length of TSC  |  |
| Aims (general overview of what the TSC hopes to achieve) |  |
| Objectives (list of learning outcomes) |  |
| Prior competencies expected of applicant | Has completed all core curriculum requirements and passed final FRCOphth |

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| TIMETABLE |
| Please complete the timetable below including some description of each session, e.g. general clinic, glaucoma clinic, general theatre list; indicate the number and identity of all other medical staff and the name of the consultant supervisor in each clinical session. Please do not leave any sections blank. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
| A.M. |  |  |  |  |  |
| Other medical staff |  |  |  |  |  |
| Consultant/ Supervisor |  |  |  |  |  |
| P.M. |  |  |  |  |  |
| Other medical staff |  |  |  |  |  |
| Consultant/ Supervisor |  |  |  |  |  |

|  |
| --- |
| **THIS SECTION IS TO BE COMPLETED BY THE PROGRAMME DIRECTOR or HEAD OF SCHOOL** |
| Name |       |
| LETB/Deanery |       |
| Email address |       |
| Contact address |       |
| I confirm that the LETB/Deanery and the School of Ophthalmology/Specialty Training Committee support the continuous recognition of this post. |
|  |
| Signature |  |
| Date |    /    /     DD MM YYYY |