**TA2 Re-Approval form**

**Educational/Clinical Supervisor Re-approval Form: Thames Valley and Wessex**

Trainers/ Educational Supervisors first re-approval will take place at 2 years, and 5 yearly thereafter to maintain GMC approval. Please see ‘Guide for TA2’ to ensure sufficient information is supplied on completion of this form.

An Interview (typically 45-60mins) will be carried out to check the details of the form and make recommendations as required.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Item*** | ***Applicant’s Details*** | | | | | | | | | |
| ***1.1*** | *Applicant’s Name*  *(Full name and known as)* | |  | | | | | | | |
| ***1.2*** | *GMC Number* | |  | | | | | | | |
| ***1.3*** | *Practice Name and Full Address*  *(Including branch /merged practices)* | |  | | | | | | | |
| ***1.4*** | *Applicant’s email* | |  | | | | | | | |
| ***1.5*** | *Practice Manager name and email* | |  | | | | | | | |
| ***1.6*** | *Practice NACS Code*  *(e.g. J12345)* | |  | | ***1.7*** | *Programme* | |  | | |
| *Patch Associate Dean* | | |  | | | | | | |
| *Other Practice members interviewed (optional):* | | |  | | | | | | |
| *Date of last (re)-approval****:*** | | |  | | | | | | |
| *CQC rating of practice with date (include recommendations and actions if applicable)* | | |  | | | | | | |
| *Progress with previous areas for development / agreed actions (from last report)* | | |  | | | | | | |
| *Please describe how you ensure safe and effective patient care* | | |  | | | | | | |
| *How do you establish and maintain an environment for learning?* | | |  | | | | | | |
| *Describe how you teach and facilitate learning* | | |  | | | | | | |
| *Please describe your timetable and the protected time you are given for your ES duties and development* | | |  | | | | | | |
| *How do you enhance learning through assessment?* | | |  | | | | | | |
| *How do you support and monitor educational progress?* | | |  | | | | | | |
| *How do you guide personal and professional development of your trainee?* | | |  | | | | | | |
| *How do you ensure continuous professional development as an educator? (Attach educational PDP, trainers meetings / faculty day attendance dates)* | | |  | | | | | | |
| *Please attach feedback from your trainees* | | |  | | | | | | |
| *Are there any issues you need help or advice with?* | | |  | | | | | | |
| *Do you have any GMC or health-related concerns?* | | |  | | | | | | |
| *Date of most recent trainer course/ Experienced trainer course (latter minimum 5 yearly)* | | | |  | | | | |
| *Have you discussed your trainer role at your annual appraisal?* | | | |  | | | | |
| *Have you received feedback regarding your e-portfolio use and WPBA?* | | | |  | | | | |
| *SECTION below to be completed by assessor:* | | | |  | | | | |
| *Highlights and Agreed areas for development* | | *Highlights:*  *Requirements:*  *Observations:* | | | | | | |
| *Lead Educator approving* | | *Name* | | | | | *Date* | |
| *Approval granted?* | | *Y/N*  *Please comment on any requirements:*  *Approval interval:* | | | | | | |
| *No of trainees approved to train* | |  | | | | | | |

*Section to be completed by 2nd reviewer (Approvals team):*

|  |  |
| --- | --- |
| *Name of 2nd Reviewer* |  |
| *Date* |  |
| *Comments* |  |

|  |  |
| --- | --- |
| *Report Approved by GP-STC* | *Dr Manjiri Bodhe*  *Head of School of Primary Care (GP), Health Education England Thames Valley and Wessex*  *Date:* |