



# FORM FOR REGISTRATION FOR A CERTIFICATE OF COMPLETION OF TRAINING (CCT)

Please complete in block capital letters and black ink. Any illegible forms will be returned.

**PERSONAL DETAILS :**

<b>Title :</b> <input type="text"/>		<b>Forename(s) : (in full)</b> <input type="text"/>	
<b>Last Name : (as registered with the GMC)</b> <input type="text"/>		<b>Sex :</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Nationality :</b> <input type="text"/>
<b>Correspondence Address :</b> <input type="text"/> <input type="text"/> <input type="text"/>		<b>Contact Telephone Number :</b> <input type="text"/>	
<b>City :</b> <input type="text"/>		<b>Contact Email Address :</b> <input type="text"/>	
<b>Postcode :</b> <input type="text"/>	<b>GMC Registration Number :</b> <input type="text"/>		
<b>Country :</b> <input type="text"/>		<b>Date of GMC Full Registration :</b> <input type="text"/>	
<b>Primary Medical Qualification :</b> <input type="text"/>		<b>Medical School : (name and country)</b> <input type="text"/>	
<b>Date Qualified :</b> <input type="text"/>			
<b>GP Vocational Training Number :</b> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

**IF YOU ARE ON, OR ARE DUE TO BEGIN A FORMAL TRAINING SCHEME  
PLEASE PROVIDE THE FOLLOWING INFORMATION :**

<b>Deanery :</b> <input type="text"/>	
<b>Start Date :</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<b>Planned Completion Date :</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
Please inform the Certification Unit if you change deaneries or if your planned date of completion changes	

**COMPLETED TRAINING :**

Date From :	Date To :	Grade :	Specialty :	Hospital & Town or GP Practice:	Full or Part time*	Prior Approval for GP Training?	Training Evaluated & Accepted by JCPTGP / RCGP?
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If Part Time please state number of sessions per week or percentage of full time worked

**PLANNED TRAINING :**

Date From :	Date To :	Grade :	Specialty :	Hospital & Town or GP Practice:	FT / *PT :	Prior Approval for GP Training?
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No
dd / mm / yy	dd / mm / yy					<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If Part Time please state number of sessions per week or percentage of full time worked

**PAYMENT :**

I have enclosed a cheque to cover the current registration fee made payable to :  
 Royal College of General Practitioners, 2nd Floor, 31 Southampton Row, London, WC1B 5HJ (see website for current fee)

**DECLARATIONS :**

**DATA PROTECTION**  
 Personal information contained on this application form shall be used solely for the RCGP carrying out any reasonable activity of the administration of specialist registration and certification. The RCGP may also use this information for the purposes of sending you information about products and services which the RCGP produces and believes will be of interest to you during your training. This data will be disclosed as part of the process of administering your training programme or application for registration to relevant third parties. The RCGP occasionally allows its mailing lists to be used by other bodies under mutual agreement. The RCGP confirms that the information on this form is held subject to regulation of the Data Protection Act 1988.

I give permission for my personal details to be made available to a third party(ies) as required for the purposes of monitoring, assessing and certifying my specialist training :

Date :  /  /

**ACCURACY**  
 I understand that the information provided in this application form is accurate and I understand that any false information may render my application / enquiry null and void. Further enquiries related to any or all of the posts described may be made by the RCGP. My GMC registration, or equivalent, is not subject to any referral, suspension or conditions I have not made the RCGP aware of.

Date :  /  /

Please print your full name (title, first name and surname in block letters below :