TRAINING POST VERIFICATION FORM FOR APPLICANTS SEEKING CERTIFICATION OF INDIVIDUAL TRAINING POSTS UNDER ARTICLE 25 OF EU DIRECTIVE 2005/36/EC

INSTRUCTIONS: THIS FORM IS TO BE COMPLETED BY THE POSTGRADUATE TRAINING BODY RESPONSIBLE FOR THE TRAINING POST WHICH THE TRAINEE WISHES TO HAVE CERTIFIED. THE COMPLETED FORM SHOULD BE RETURNED BY THE APPLICANT TO: REGISTRATION SECTION, THE MEDICAL COUNCIL, KINGRAM HOUSE, KINGRAM PLACE, DUBLIN 2

N.B: ONE FORM SHOULD BE COMPLETED FOR EACH POST REQUIRING CERTIFICATION

NAME OF CLINICAL SITE:______________________________

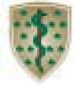
POST TYPE (SHO, REGISTRAR ETC):______________________________

POST PART OF RECOGNISED SPECIALIST TRAINING PROGRAMME: Yes ☐ No ☐

NAME OF SPECIALIST TRAINING PROGRAMME:______________________________

SIGNATURE OF TRAINING BODY ADMINISTRATOR:______________________________

STAMP OF POSTGRADUATE TRAINING BODY:______________________________



PAYMENT FORM

MEDICAL COUNCIL - FINANCE SECTION
KINGRAM HOUSE, KINGRAM PLACE, DUBLIN 2

REGISTRATION NO

SURNAME: **(BLOCK CAPITALS)**

FORENAMES: **(BLOCK CAPITALS)**

TELEPHONE NO:

EMAIL ADDRESS:

PLEASE STATE TYPE OF PAYMENT, (E.G.ANNUAL REGISTRATION FEE)**:**

METHOD OF PAYMENT:

- ☐ **DRAFT (Drawn on Irish Bank)**
- ☐ **VISA DEBIT CARD**
- ☐ **CREDIT CARD (MASTERCARD / VISA)**
- ☐ **LASER CARD**

<u>Credit/Laser Card Payment</u>

- **CCV number MUST be entered as failure to do so will result in application being delayed**.

Please debit my Visa / Mastercard / Laser card for the sum of €__________

VISA/ MASTERCARD NO.																	Exp. Date				

CVV NO. (last 3 digits on back)			

Lasercard/ VisaDebit Card No.																				Exp. Date				

Name of Credit Card/Laser Holder (Complete in Block Capitals): ____________________________

Signature:____Date: _______________________

<u>FOR OFFICE USE ONLY:</u> **FEE TAKEN BY:_____________________________________DATE____________________________** **[TO BE COMPLETED BY STAFF MEMBER PROCESSING APPLICATION]**