**Supporting Mentors Scheme – Application Form (GPs)**

 **Mentorship Scheme Commitment and Support Information**

* The mentorship scheme supports GP’s who currently deliver – or agree to deliver – a minimum of three clinical sessions per week and are looking to conduct an additional weekly session of mentoring
* Mentorship training resulting in an industry recognised qualification
* Mentors could support up to 4 mentees (depending on availability), and will support newly qualified GP’s on the NHSE New to Practice Fellowship programme
* A financial payment of £289 per session (4hrs 10 mins) utilised for delivery of mentorship activities

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| --- | --- |
| **Name of applicant** |  |

**Personal details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **First name(s)** |  |
| **Home address** |  | **Postcode** |  |
| **Telephone** |  | **Email** |  |
| **GMC number** |  | **Are you on the National Medical Performers List?** | Yes |[ ]
|  |  |  | No |[ ]
| **Qualifications and dates.****Please include any relevant mentoring qualifications/training.** | **Qualification** | **Date** | **Awarding organisation** |
|  |  |  |  |
| **If you do not hold a mentorship/training qualification and would like to undertake a mentorship course, please specify here** | Yes |[ ]
|  | No |[ ]

**Scheme application**

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| **What are your personal objectives in applying to this scheme?** |
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| **Why is mentoring others important to you?** |
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| **Please provide examples of any recent actions you have taken to support the development of others.** |
|  |
| **Please provide details of any previous mentoring experience and the outcomes achieved (if any).** |
|  |
| **Please provide the details of two professional references to support your application.** | **Reference 1** | **Reference 2** |
| **Name** |  |  |
| **Job title** |  |  |
| **Email** |  |  |
| **Telephone** |  |  |
| **Relationship to applicant** |  |  |

**Practice details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Proposed start date** |  | **Number of clinical sessions per week** |  |
| **Number of fellows you could mentor at once (maximum 4 at once)** |  | **Funding reimbursement -** **Claim as individual or via practice?** |  |
| **Name of practice** |  |
| **Practice address** |   |
| **Practice code** |  |
| **Practice telephone** |  |
| **Is the practice a training practice?** | Yes |[ ]
|  | No |[ ]
|  |
| **Name of practice manager** |  |
| **Email for practice manager** |  |
| **Telephone for practice manager** |  |

**Agreement**

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| **I understand that if I am accepted on this scheme, I will need to commit to a minimum of 1 year and attend any training sessions or associate meetings needed.****I confirm that:**1. **If I secure and confirm a place on this scheme and fail to attend any training element without a justifiable reason, I will be charged**
2. **the information given in this form is accurate and is consistent with the criteria of the Supporting Mentors Scheme and that information contained in this form will be shared with NHS England for the purposes of monitoring the scheme**
3. **data and information with regards to any activities in relation to the programme can be shared for monitoring and evaluation purposes**
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| Name of prospective GP mentor |  |
| Signature of prospective GP mentor |  | Date |  |
|  |
| **On behalf of the employing practice, I confirm that the doctor currently undertakes a minimum of 3 clinical sessions at the practice.** |
| Name of authorising employer (e.g. practice manager) |  |
| Signature of authorising employer (e.g. practice manager) |  | Date |  |

**For completion by STP**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of decision** |  |
| **Decision** | Accepted |[ ]
|  | Declined |[ ]
| **If application is declined, please specify reason** |  |
| **Proposed date funding to commence** |  |
| **Signature of STP lead** |  | **Date** |  |