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 **Trainee Registration form**

**Please fill in all sections**

**SECTION 1**

|  |  |
| --- | --- |
| Title (Dr, Mr, Mrs, Ms etc.) |  |
| First name |  |
| Surname |  |
| Your Job Title *as stated in your job description (nurse/doctor is insufficient information)* |  |
| Place of Work – name of clinic, hospital or practice, including postcode |  |
| Training location if different from above: |  |
| NHS Trust |  |
| Mobile telephone number |  |
| Email |  |
| **Name of Registered *Competency* Trainer** refer to [www.stif.org.uk/comp\_trainers](http://www.stif.org.uk/comp_trainers) |  |
| Trainer’s workplace |  |
| Trainer's email |  |

**SECTION 2**

**Please confirm the following statements are true, deleting where appropriate and providing additional information if necessary**

|  |  |  |
| --- | --- | --- |
| **YES/NO** | I have completed a minimum of 25 clinics in the last 2 years in a Level 3 GUM service / fully integrated SRH service seeing both male and female patients and managed them independently. At least 25% of the patients seen in these clinics were male. Each clinic session was 3 hours or more in duration.  *Please state actual number of clinics done according to above definition:* | **INSERT NUMBER** |
| **YES/NO** | I have completed the additional competencies and have been awarded a STIF *Intermediate* Certificate of Competence v2020 dated: | **INSERT DATE** |

**SECTION 3**

**I confirm** thatthe above information is correct. I confirm that the above information can be retained to set up my training recordandmy training data can be retained for over 5 years to maintain my training record as appropriate.

I would like to receive e-mails about essential training updates.

**STIF *ADVANCED* TRAINEE Signature:** Date:

**I confirm** that the trainee has the appropriate level of knowledge and experience to undertake the STI Foundation *Advanced* Competency training and assessment programme. I confirm that the trainee has completed the additional assessments and holds the updated STI Foundation *Intermediate* Certificate v2020.

**I confirm** that I take responsibility for overseeing the clinical sexual health competency assessments according to the requirements set out in the STI Foundation *Advanced* Competency Trainer Handbook.

**REGISTERED COMPETENCY TRAINER Signature**: Date:

**SECTION 4**

**Please pay the registration fee as appropriate**

[ ] £450

**Please indicate method of payment**

[ ] **Invoice to employer.** *Please provide full invoicing instructions and* ***a Purchase Order*** *showing trainee’s name and covering the appropriate registration fee. Email to* [*STIF@BASHH.org*](mailto:STIF@BASHH.org)

[ ] **bank transfer** Bank details will be emailed to you.

[ ] **credit card** Payment link will be emailed to you

When your registration fee has been paid, you will be sent a web link and password to access and download the training materials.

Please scan the signed form and email to [STIF@BASHH.org](mailto:STIF@BASHH.org)

Please retain a copy for your files

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