MEDICAL & DENTAL STUDY LEAVE APPLICATION FORM

**To be submitted for approval a minimum of 6 weeks in advance of planned leave**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1 Personal Details *Please print details clearly*** | | | | | | | | | | | | | | | |
| **Name** |  | | | | | | **Designation** |  | | | | | | | |
|  |  | | | | | |  |  | | | | | | | |
| **Ward/Dept** |  | | | | | | **Sector/ Directorate/ HSCP** |  | | | | | | | |
|  |  | | | | | |  |  | | | | | | | |
| **Hospital** |  | | | | | | **Work Tel No.** |  | | | | | | | |
|  |  | | | | | |  |  | | | | | | | |
| **Pay Div** | **Pay Division** | | **Pay Group** | | **Pay Point** | | **Pay No.**  **(8 digits)** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |

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| --- | --- | --- | --- |
| **Section 2 Course Details** | | | |
| **Study Leave details** \*Delete as appropriate  **Course / conference/ meeting/ study/exam (attach copy of details)** | | | |
| **Organiser: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Course Location/Virtual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Leave requested from \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_ (dates)** | | | |
| **Title of course / conference / meeting** |  | | |
| **Total duration of course / conference / meeting** |  | | |
| **Total number of study leave days requested** |  | | |
| **Course Fees** |  | | |
| **Will you be seeking financial assistance from any other body? YES  NO** *(If YES, please give details below)* | | | |
| **Professional or Study Leave will normally be granted to the maximum extent consistent with maintaining essential services up to 30 days (including off-duty days falling within the period of leave) in any 3 year period. The year is a rolling year based on the 12 month period preceding the date of the requested leave** | | | |
| **Number of days professional/study leave already taken within the 3 year period** | |  | |
| **I CONFIRM THAT I WILL NOT CONFIRM MY PLACE ON THIS COURSE UNTIL APPROVAL HAS BEEN RECEIVED.**  **Applicant’s signature** | | | **Date** |

STUDY LEAVE APPLICATION FORM

**PLEASE NOTE THAT REMAINING SECTIONS ARE TO BE COMPLETED BY LINE MANAGER / BUDGET HOLDER.**

**MEDICAL LINE MANAGER:**

**Section 3 Support**

|  |  |  |
| --- | --- | --- |
| **Is this requested supported? YES**  **NO** | | |
| **Please indicate what benefits can be expected from the applicant undertaking the course.**  **Beneficial to NHSGGC/NHS Scotland**  **Beneficial and linked to the Job Plan**  **Beneficial and linked to PDP** | | |
| **How will the member of staff’s duties be covered during this absence?** | | |
| **If the request is NOT supported, please indicate reasons** | | |
| **Medical Line Manager**  **Name** | **Signature** | **Date** |

**CHIEF OF MEDICINE/DEPUTY MEDICAL DIRECTOR[[1]](#footnote-1):**

**Section 4 Support**

**To be completed for study leave requested outwith UK/Europe only**

|  |  |  |
| --- | --- | --- |
| **Is this requested supported? YES  NO** | | |
| **Please indicate reason(s) for decision** | | |
| **Chief of Medicine/Deputy Medical Director**  **Name** | **Signature** | **Date** |

**BUDGET HOLDER:**

**Section 5 Decision and Approval**

**Has this decision been approved?** **YES**  **NO**

**If YES, is paid leave appropriate?** **YES**  **NO**

**Course Fees** Amount **£      :**

***Please refer to NHS GGC Medical & Dental Staff Study and Professional Leave Management Guidelines (5.4, 5.5 & 5.6) before completing section below:-***

**Virtual** Amount **£      :**

**UK Based – Full Reimbursement** Amount **£      :**

**Outwith the UK but within Europe With funding**     Amount **£      :**

**Outwith UK and Europe With funding**     Amount **£      :**

**Without funding**

**This request is authorised in accordance with the NHS GGC Medical & Dental Staff Study and Professional Leave Management Guidelines. Payment of course fees as detailed should be charged to the following budget:**

**Cost Centre**       **Detail Code**

**Signature of Budget Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. To be signed by Deputy Medical Director if application is submitted by COM [↑](#footnote-ref-1)