**Instructions to applicants:**

1. **This certificate can only be signed by a Consultant or equivalent. For the purposes of this documentation, Consultant includes General Practitioners, Clinical Directors, Medical Superintendents, Academic Professors and anyone on the specialist register.**
2. **Consultants are only eligible to sign this certificate if they have worked with you for a minimum continuous period of three months whole-time equivalent wholly within the 3 years prior to the advertised post start date for which you are applying.**
3. **You must be rated as demonstrated for each and every outcome listed on this certificate. If you cannot demonstrate that you have achieved all your outcomes in one post, you may submit additional Alternative Certificates to demonstrate the full set of outcomes. If you cannot demonstrate each and every outcome, you will not be eligible for Specialty Training at ST1 or CT1 level.**
4. **Before you pass the form to the signatory, please complete and sign the declaration below.**
5. **The certificate MUST be complete in every detail, including details about the person completing it for you. Incomplete certificates may lead to your application being deemed ineligible for that recruitment round. It is strongly recommended that you check the form after your signatory has completed it using the attached checklist.**
6. **A checklist is available at the end of this form to ensure you have completed all relevant sections correctly.**
7. **You must then scan, upload and attach it (preferably as one single document) to your application form before submission.**
8. **Because of changes to the Foundation Curriculum (effective August 2014), only the 2016 version of this form will be accepted.**

|  |  |
| --- | --- |
| **Applicant declaration:** | |
| I confirm that I have attained all of the competences signed off in this form **and** that I have worked for the consultant who has completed this certificate for a minimum continuous period of three months whole time equivalent within the three years prior to the advertised post start date for which I am applying. | |
| **Applicant Name** |  |
| **Applicant GMC No** |  |
| **Applicant Signature** |  |

**Instructions to those completing and signing the certificate:**

*The person who has asked you to fill in this form has applied for Specialty Training in the United Kingdom at ST1 or CT1 level. In order to process their application, we need to know that they have achieved the outcomes listed in this certificate to the standard expected of UK foundation year 2 doctors. Before filling in this certificate please view the standards expected of foundation programme doctors at* [***http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment***](http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment)

***Please note that you must only confirm that the applicant has met the outcomes listed below if you KNOW they are competent. You do not need to have witnessed them all within the last three years. The applicant needs to have worked with you in the last 3 years (i.e. since August 2013), for a minimum continuous period of three months whole time equivalent, and you need to have evidence that they have maintained any competencies that you have not witnessed recently. This evidence might come from your own observations, or from a doctor working as a senior trainee (i.e. ST5 level or above) who you know has witnessed the applicant demonstrate that competence.***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **About the person signing the certificate:** | | | | | | | | | | | |
| **Your name:** | | | |  | | | | | | | |
| **Professional status :** | | | |  | | | | | | | |
| **Current post:** | | | |  | | | | | | | |
| **I confirm that I have known and worked with the applicant for a minimum of 3 continuous months (whole time equivalent)** | | | | Yes/No | | | | | | | |
| **Address for correspondence:** | | | |  | | | | | | | |
| **Email address:** | | | |  | | | | | | | |
| **Your UK GMC Number:** | | | |  | | | | | | | |
| If you are not registered with the UK GMC please give: | | | | | | | | | | | |
| **Name of your registering body:** | | | |  | | | | | | | |
| **Your Registration Number:** | | | |  | | | | | | | |
| **Web site address where this information can be verified:** | | | | www. | | | | | | | |
| **Alternatively, you may attach photocopy evidence of your professional status to this certificate** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **About how you know the applicant and their work:** Please give details of the post this applicant held at the time when you observed their work. *Three continuous months (whole time equivalent) of this post MUST have been completed by the time of the application submission deadline and since August 2013.* | | | | | | | | | | | |
| **Specialty and level** | | | | |  | | | | | | |
| **Dates post held (from : to)** | | | | | From: | | | To: | | | |
| **Name of Hospital** | | | | |  | | | | | | |
| **Country** | | | | |  | | | | | | |
| **Applicants name:** | | |  | | | | **Date of completion:** | |  | | |
| **About the applicant’s demonstrable outcomes:**  Please complete one of the three boxes on the right hand side for **ALL** competences as follows:  **Tick** the box for those competences you have **personally witnessed** or those which you are **unable to confirm**  Enter the **initials** of your colleague in the corresponding column where you are signing off a competence you have **not personally witnessed**. You will be required to list the details of these colleagues later in the form (page 11) | | | | | | | | | | | |
| Section 1:  The foundation doctor as a professional and a scholar | | | | | | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **1. Professionalism** | | | | | | | | | | | |
| **Behaviour in the workplace** | Acts with professionalism in the workplace and in interactions with patients and colleagues | | | | | | | |  |  |  |
|  | Acts as a role model and where appropriate a leader for medical students and other junior doctors, and assists and educates other staff | | | | | | | |  |  |  |
| **Time management** | Is punctual and organised | | | | | | | |  |  |  |
|  | Delegates tasks and ensures that they are completed | | | | | | | |  |  |  |
| **Continuity of care** | Brings accurate information to handover and indicates priorities effectively | | | | | | | |  |  |  |
|  | Organises handover and task allocation, anticipating problems for the next clinical team/shift and takes pre-emptive action where required | | | | | | | |  |  |  |
| **Team working** | Displays understanding of personal role within their team including supporting the team leader and listening to the views of other healthcare professionals | | | | | | | |  |  |  |
|  | Organises and allocates work within their clinical team to optimise effectiveness | | | | | | | |  |  |  |
| **Leadership** | Demonstrates a leadership role within the team in certain clinical situations | | | | | | | |  |  |  |
|  | Demonstrates extended leadership role within the team by making decisions and dealing with complex situations across a range of clinical and non-clinical situations | | | | | | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | | | | | | |
| **Applicants name:** | |  | | | | **Date of completion:** | | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **2. Relationship and communication with patients** | | | | | | |
| **Treats the patient as the centre of care within a consultation** | Prioritises the needs of patients above personal convenience without compromising personal safety or safety of others | | |  |  |  |
| Works in partnership with patients in an open and transparent manner, treats patients as individuals and respects their perspectives/views on their own treatment | | |  |  |  |
| Works with patients and colleagues to develop sustainable individual care plans to manage patients’ acute and long-term conditions | | |  |  |  |
| **Communication with patients** | Communicates effectively and with understanding and empathy in straightforward consultations | | |  |  |  |
| Demonstrates increasing ability and effectiveness in communicating more complicated information in increasingly challenging circumstances | | |  |  |  |
| Deals increasingly independently with queries from patients and relatives | | |  |  |  |
| **Communication in difficult circumstances** | Breaks bad news to patients or care/relative effectively and compassionately, and provides support, where appropriate | | |  |  |  |
| Recognises where patient’s capacity is impaired and takes appropriate action | | |  |  |  |
| **Complaints** | Recognises situations which might lead to complaint or dissatisfaction | | |  |  |  |
| Apologises for errors and takes steps to prevent/minimise impact | | |  |  |  |
| **Consent** | Obtains consent as appropriate in accordance with *Consent: patients and doctors making decisions together (2008),* including for core procedures | | |  |  |  |
| **3. Safety and clinical governance** | | | | | | |
| **Risks of fatigue, ill health and stress** | Recognises that fatigue and health problems in healthcare workers (including self) can compromise patient care and where appropriate, must be urgently addressed | | |  |  |  |
| If applicable recognises fatigue/stress/illness in members of the clinical team and seeks senior guidance to reduce this | | |  |  |  |
| **Quality and safety improvement** | Delivers high quality care in accordance with local/national guidelines | | |  |  |  |
| Manages, analyses and presents at least one quality improvement project and uses the results to improve patient care | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **4. Ethical and legal issues** | | | | | | |
| **Medical ethical principles and confidentiality** | Practises in accordance with the principles of *Good Medical Practice (2013)*, *The Trainee Doctor (2011)* and *Confidentiality (2009)* | | |  |  |  |
| **Legal framework of medical practice** | Takes personal responsibility for and is able to justify decisions and actions | | |  |  |  |
| **Comprehension of relevance of outside bodies to professional life** | Recognises many organisations and bodies that are involved in medical education and regulation of medical practice | | |  |  |  |
| **5. Teaching and training** | | | | | | |
| Delivers presentations and teaching sessions which support learning | | | |  |  |  |
| Participates in the assessment of medical students or other healthcare professionals and provides constructive feedback | | | |  |  |  |
| Reflects on feedback from learners and supervisors to improve own teaching and training skills | | | |  |  |  |
| **6. Maintaining good medical practice** | | | | | | |
| **Lifelong learning** | Maintains personal development portfolio by recording learning needs and personal reflection including career development and planning | | |  |  |  |
| Recognises personal learning needs, addresses these proactively and sets SMART (specific, measurable, achievable, realistic, time limited) goals | | |  |  |  |
| **Evidence, guidelines, care protocols and research** | Recognises, understands and follows appropriate guidelines | | |  |  |  |
| Finds and interprets evidence relating to clinical questions | | |  |  |  |
| Demonstrates the use of literature, guidelines and experience in the development of clinical skills over the previous year | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Section 2:  The foundation doctor as a safe and effective practitioner | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **7. Good clinical care** | | | | | | |
| **Makes patient safety a priority in clinical practice** | Delivers high-quality reliable care in accordance with clinical care pathways, care bundles, protocols and consultant prescription | | |  |  |  |
| Recognises and works within limits of competency requesting appropriate assistance/senior guidance to ensure patient safety | | |  |  |  |
| Recognises when patient safety is at risk and institutes change to reduce risk | | |  |  |  |
| **Ensures correct patient identification** | Ensures patient safety by positive identification of the patient at each encounter | | |  |  |  |
| Ensures correct patient identification before obtaining consent for surgery/procedures | | |  |  |  |
| **History and examination** | Obtains accurate patient history and examination utilising all relevant sources of information | | |  |  |  |
| Performs accurate physical examination and elicits physical signs | | |  |  |  |
| Presents patient history and findings succinctly and accurately | | |  |  |  |
| Rapidly makes a focused clinical assessment in different settings and with uncooperative patients | | |  |  |  |
| **Diagnosis and clinical decision making** | Makes appropriate differential diagnosis and formulates a management plan | | |  |  |  |
| Reviews initial diagnosis, refines problem, lists and plans appropriate strategies for investigation and management | | |  |  |  |
| **Undertakes regular patient review** | Takes responsibility for regular reviews and expedites patient investigation and management | | |  |  |  |
| Refines appropriate strategies for investigation and management and leads regular reviews of treatment response to oversee patients’ progress along treatment plan | | |  |  |  |
| **Safe prescribing** | Ensures correct patient identification when prescribing | | |  |  |  |
| Prescribes medicines accurately and unambiguously and regularly reviews drug chart | | |  |  |  |
| Prescribes appropriately for common important presentations e.g. exacerbation of chronic obstructive pulmonary disease, congestive cardiac failure, pain | | |  |  |  |
| Recognises and adheres to local restrictions to prescribing e.g. relating to chemotherapy and immunosuppressant agents | | |  |  |  |
| Anticipates change in medication required on admission, during stay, at discharge and in outpatients | | |  |  |  |
| Use strategies other than prescribing to manage patients’ symptoms | | |  |  |  |
| Only prescribes or administers chemotherapy or immunosuppressants after completing specific training | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |
|  | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **Safe use of medical devices** | Demonstrates correct use of relevant medical devices and interpretation of non-invasive monitoring | | |  |  |  |
| **Infection control and hygiene** | Demonstrates continuously high standard of practice in infection control techniques | | |  |  |  |
| Complies with local requirements for learning related to infection control | | |  |  |  |
| Complies with local requirements for immunisation against communicable disease | | |  |  |  |
| **Medical record keeping and correspondence** | Maintains accurate, contemporaneous notes | | |  |  |  |
| Seeks out and records results of investigations and tests in a timely manner | | |  |  |  |
| Formulates accurate and succinct clinic letters and discharge summaries | | |  |  |  |
| **Interface with different specialties and with other professionals** | Makes appropriate referrals within the hospital | | |  |  |  |
| Takes part in the process of referral from primary to secondary and/or tertiary care and vice versa | | |  |  |  |
| Able to make referrals across boundaries and through networks of care | | |  |  |  |
| **8. Recognition and management of the acutely ill patient** | | | | | | |
| **Promptly assesses the acutely ill, collapsed or unconscious patient** | Uses an Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assessing acutely unwell or collapsed patients | | |  |  |  |
| Recognises patients with acute illness requiring urgent/emergency treatment and initiates early management | | |  |  |  |
| Rapidly performs primary assessment, evaluates and recognises the severity of illness in acutely ill or collapsed patients | | |  |  |  |
| Recognises the different prognostic significance of the component elements of Glasgow Coma Scale (GCS) or equivalent and takes appropriate action | | |  |  |  |
| **Responds to acutely abnormal physiology** | Takes appropriate timely action to treat a patient with abnormal physiology | | |  |  |  |
| Anticipates and plans appropriate action to prevent deterioration in vital signs | | |  |  |  |
| **Manages patients with impaired consciousness including seizures** | Investigates causes of impaired/deteriorating consciousness and seizures and commences treatment to correct them | | |  |  |  |
| Manages / treats the unconscious or convulsing patient | | |  |  |  |
| Understands the impact on the activities of daily living of convulsions and communicates these to patients and their carers/relatives | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **Manages pain** | Safely prescribes and administers common analgesic drugs including patient controlled analgesia | | |  |  |  |
| Anticipates and prevents pain whenever possible | | |  |  |  |
| Ensures safe prescribing, tailoring to changing requirements throughout patient’s care journey | | |  |  |  |
| **Manages sepsis** | Identifies and manages sepsis early in accordance with local protocols | | |  |  |  |
| Identifies and treats the focus of infection in accordance with sepsis resuscitation bundle e.g. <http://www.survivingsepsis.org> | | |  |  |  |
| **Manages acute mental disorder and self-harm** | Assesses and manages patients’ mental health including the risk of harm to self and others | | |  |  |  |
| Describes when and how to apply the relevant mental health and capacity legislation | | |  |  |  |
| **9. Resuscitation and end of life care**  ***N.B. ALL applicants must submit a valid ALS certificate either at Assessment Centre or to their first employer before they can begin ST/CT1 training*** | | | | | | |
| **Resuscitation** | Knows how to initiate and respond to a crash call | | |  |  |  |
| Is trained in advanced life support (ALS or equivalent)  *Not verified by this certificate* | | |  |  |  |
| Initiates ALS resuscitation and leads the team where necessary | | |  |  |  |
| **End of life care and appropriate use of Do Not Attempt Resuscitation (DNAR) orders/ advanced decisions** | Understands the principles of providing high quality end of life care including the use of DNAR orders as outlined in *Treatment and care towards the end of life: good practice in decision making* (GMC, 2010) | | |  |  |  |
| Takes part in discussions regarding end of life care and DNAR orders | | |  |  |  |
| Uses the local protocol for deciding when not to resuscitate patients | | |  |  |  |
| **10.** **Patients with long-term conditions** | | | | | | |
| **Manages patients with long-term conditions** | Accurately re-prescribes long-term medications checking for side effects and significant interactions in the context of the current illness (see *Good Clinical Care: Safe Prescribing,2008*) | | |  |  |  |
| Manages long-term conditions during episodes of acute care | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Personally witnessed** | **Initials of witnessing colleague** | **Unable to confirm** |
| **Supporting patient decision making** | Encourages and assists patients to make decisions about their care | | |  |  |  |
| Works with the MDT to plan care for those with long-term illness | | |  |  |  |
| Encourages and ensures evaluation of patients’ capacity to self-care | | |  |  |  |
| **Nutrition** | Takes a basic nutrition history and considers this in planning care | | |  |  |  |
| Ensures adequate nutrition for patients with acute illness and long-term conditions | | |  |  |  |
| **Discharge planning** | Recognises and records when patients are medically fit for discharge | | |  |  |  |
| Produces a competent, legible discharge summary that identifies principle diagnoses, key treatments/interventions, discharge medication and follow-up arrangements in a timely manner | | |  |  |  |
| **Health promotion, patient education and public health** | Explains to patients the possible effects of their lifestyle, including the effects of diet, nutrition, smoking, alcohol and drugs (separately and in combination) | | |  |  |  |
| Recognises and uses opportunities to prevent diseases and promote health | | |  |  |  |
| **11. Investigations** | | | | | | |
| See: <http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>  for commonly requested investigations | Ensures that specimens and requests for investigation have the correct patient details | | |  |  |  |
| Requests/arranges/interprets appropriate ECG, laboratory tests and other investigations to aid diagnosis | | |  |  |  |
| Ensures that test results are from the correct patient | | |  |  |  |
| Interprets basic radiographs (chest, abdomen and bones) and identifies correct and incorrect positions of nasogastric tubes | | |  |  |  |
| Maintains and improves interpretative skills across an increasing range of investigations and clinical outcomes | | |  |  |  |
| **12. Procedures** | | | | | | |
| See <http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>  for list of core procedures | Competently performs and, when sanctioned by a supervisor, teaches medical students in the required core procedures, either in the workplace or on simulated patients | | |  |  |  |
| Maintains and improves skills in the core procedures e.g. reliably able to perform venous cannulation in the majority of patients in more challenging circumstances such as during resuscitation | | |  |  |  |
| **Verifying consultant’s signature confirming details above:** | | | | | | |
| **Applicants name:** | |  | **Date of completion:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Declaration by person signing this certificate:**  **REMINDER:** We would wish to remind signatories of their professional responsibilities under the General Medical Council’s guidance “Good Medical Practice” (paragraph 71) which states that “*you must do your best to make sure that any documents you write or you sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents*”. **Failure to do so renders you, the signatory, at risk of being referred to your regulatory authority (the GMC or equivalent).** Patient Safety must remain your primary concern. | | | |
| A)  I confirm that I have viewed the official Foundation Programme website (<http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>) and that I am aware of the standards expected of UK Foundation Programme year 2 doctors. | | | |
| B)  I confirm that the doctor named above has worked for me for a minimum of three months whole time equivalent since August 2013 and prior to application submission. | | | |
| C1)  I can confirm that I have observed the doctor named above demonstrate all of the listed competences OR  C2)  where I have not personally observed them, I have received alternative evidence that I know to be reliable from a colleague working satisfactorily as a senior trainee (i.e.at ST5 or above). **I have listed those providing evidence on the next page.** | | | |
| NB: *This form is invalid unless boxes A, B* ***and*** *either C1* ***or*** *C2 above are checked.* | | | |
| **Verifying consultant’s signature confirming the above:** | | | |
| **Applicants name:** |  | **Date of completion:** |  |
| **HOSPITAL STAMP**  **If not available, please attached a signed compliment slip and give hospital name and website address** |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **List of people whose evidence I have used in signing this certificate:** Where I have not personally observed them, I have received alternative evidence that I know to be reliable from a colleague working satisfactorily as a senior trainee (i.e. at ST5 or above), as detailed below. Please ensure that you enter the section/s of the form where each individual has observed outcomes ***Please note that, as part of the verification process, witnesses may be contacted to verify and confirm that they have provided you with such evidence***: | | | | | |
| **Section:** | | | | | |
| **Their name:** | |  | | | |
| **Professional status :** | |  | | | |
| **Work Address:** | |  | | | |
| **Email address:** | |  | | | |
| **Section:** | | | | | |
| **Their name:** | |  | | | |
| **Professional status :** | |  | | | |
| **Work Address:** | |  | | | |
| **Email address:** | |  | | | |
| **Section:** | | | | | |
| **Their name:** | |  | | | |
| **Professional status :** | |  | | | |
| **Work Address:** | |  | | | |
| **Email address:** | |  | | | |
| **Verifying consultant’s signature confirming the above:** | | | | |
| **Applicants name:** |  | | **Date of completion:** |  |

**CHECKLIST FOR CANDIDATES SUBMITTING AN ALTERNATIVE CERTIFICATE**

**Page 1**

1. Have you put your name & GMC number in the Applicant Declaration section?
2. Have you signed the Applicant Declaration?

**Page 2**

1. Has the consultant you have asked to sign the certificate filled in their details correctly?
   1. Name
   2. Professional status
   3. Current post
   4. Address for correspondence
   5. Email address
   6. GMC number OR if NOT registered with the UK GMC, the name of the registering body and their registration number and a web site address where that can be verified OR photocopy evidence of their registration
2. Have they told us how they know you?
   1. Specialty and level of the post where you worked with them
   2. Dates post held
   3. The name of the hospital
   4. Country
3. Have they put your name and date of completion of form at the bottom of this page?

**Pages 3 to 9**

1. Has the consultant signing this certificate completed one of the three boxes for each listed competence?
2. Have they put your name and date of completion of form at the bottom of each page?

**Page 10**

1. Have they ticked ALL boxes (A, B **and** C1 or C2) on the declaration?
2. Have they signed the declaration and printed their name and the date?
3. Have they put your name and date of completion of form at the bottom of this page?
4. Is there a hospital stamp?

**Page 11**

1. Have they listed everyone whose evidence they relied upon for any of the sections?

**If the answers to any of the above questions are NO, then your certificate will be rejected and you will be deemed not to have demonstrated that you have achieved foundation competence**.

SCAN, UPLOAD AND ATTACH THIS CERTIFICATE TO YOUR

APPLICATION FORM BEFORE SUBMISSION

(guidance about this can be found in the Applicant’s Guide)