**Out of Hours Provider - Clinical Supervisor Re-Approval Statement**

This form should be completed by the OOH providers Medical Director & submitted electronically

*Please complete all areas on behalf of your OOH service Provider Organisation. The information provided will assist the LETB with consideration of the re-approval of the Clinical Supervisor named below. Incomplete forms will delay the re-approval of your clinical supervisor*

This form is about Dr……………………… GMC No…………………. who is currently due for their three yearly re-approval as an Out of Hours Clinical Supervisor. First date of approval in this role……………

**OOH Training:** - (*over the last 12 months period)*

Number of Clinical Supervisor sessions undertaken by this supervisor:

Number of GP trainees supervised:

**Summary of Trainee feedback on the CS** (delete as appropriate):

Excellent / Satisfactory / Cause for concern

**OOH provider feedback:-**

Excellent / Satisfactory / Cause for concern

**Comments:**

**Please record any Significant Events/ Complaints or other Concerns naming this CS:-**

**Your organisations appraisal or performance review of this CS:**

Date of appraisal/performance review:

Relevant learning needs identified:

**Declaration:**

From the information availAble i cONFIRM the Out of hours service provider..............................................................

has no concerns about dr …………………………………………’s clinical AND EDUCATIONAL practice.

**Medical Director Name and Signature: Date:**

*Please tick the box to confirm your declaration.*

Trainer