

**Postgraduate Diploma in Travel Medicine**

APPLICATION FORM

**To be completed by the APPLICANT**

Please complete all sections of this form. Incomplete or unsigned forms cannot be processed and will be returned. If you require further information, please email [PGDipTravelmed@rcpsg.ac.uk](file:///C%3A%5CUsers%5Chelenwa%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CZFCZNULL%5CPGDipTravelmed%40rcpsg.ac.uk) or phone 0141 221 6072 ext 420.

Please return your completed form to: [PGDipTravelmed@rcpsg.ac.uk](file:///C%3A%5CUsers%5Chelenwa%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CZFCZNULL%5CPGDipTravelmed%40rcpsg.ac.uk)

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| **SECTION 1 APPLICATION DETAILS**  |
| Please complete this form for the part-time online distance learning Postgraduate Diploma in Travel Medicine course. |
| Ref No*(Official use only)*:        |
| Where did you hear about this course?       |

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| **SECTION 2 PERSONAL DETAILS** |
| Title:       |  |
| Family Name:       |
| Forename(s):       |
| **SPECIAL REQUIREMENTS**It is the responsibility of the applicant to notify the College of any educational adjustments they required when submit this application.Do you require any educational adjustments for undertaking this course? [ ]  Yes [ ]  No  | If yes, applicants requesting educational adjustments must be supported by evidence. Do you currently have an Educational Support Plan or Assessment Report from an educational psychologist? [ ]  Yes [ ]  No *You will be required to provide the relevant information and documents to support any educational adjustments required.* *e.g. A current Dyslexia Assessment Report.*   |
| Do you consider English as your first language? [ ]  Yes [ ]  No  | If no, do you have an English language certificate? [ ]  Yes [ ]  No Do you currently hold an academic qualification from previously studying an English taught course? [ ]  Yes [ ]  No If yes, please state the qualification obtained and institute attended:***You must provide a copy of your certificate along with your application.*** |
| Please state which of the following English language certificates you hold: | TEFL [ ]  IELTS [ ]  None [ ]  Other [ ]  If other, please specify***You must provide a copy of your certificate along with your application.*** |
| Do you wish to attend the residential elements of the course in-person or online? There will be two residential weeks in total.[ ]  Both in person (In Glasgow) [ ]  Both online [ ]  January Residential In-Person [ ]  October Residential In-Person Only |
| Please confirm that you have suitable information technology (IT) and the relevant IT skill to complete this course? [ ]  Yes [ ]  No  |

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| **SECTION 3 CONTACT DETAILS** |
| **HOME**  |
| Address:       |
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| Postcode/zip:       |
| Country:       |
| Telephone/Mobile:       |
| E-mail:       |
| Fax:       |
| Please confirm your preferred method of contact:  Phone: [ ]  E-mail: [ ]  Letter: [ ]  |

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| **SECTION 4 QUALIFICATIONS, PROFESSION AND REGULATORY BODY** |
| Please list your professional qualification(s), your current profession and name of your regulatory body. *Please ensure you provide photocopies of your qualifications with your application form. Your application form cannot be processed without evidence of your qualifications.* |
| **Name of awarding institution/college** | **Dates attended** | **Degree/Diploma** | **Main subjects** |
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| Profession:       | Regulatory Body:      |

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| **SECTION 5 CURRENT EMPLOYMENT** |
| Please provide details of current  |
| Job title:       | Date of commencement:        |
| Employer’s name:       |
| Employer’s address:       |
| Email:       | Telephone:       Fax:       |
| Please provide a description of your main responsibilities (include any information relevant to travel medicine):

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Please provide a summary of previous employment:

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| **Job Title** | **Dates Employed** | **Name of Employer** | **Summary of Responsibilities** |
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| **SECTION 6 PERSONAL STATEMENT AND COURSE BENEFITS TO YOU** |
| Please indicate, in no less than 300 words, why you want to undertake this course and how you think it may benefit you in the future:

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| **SECTION 7 FINANCE** |
| Please indicate how you intend to fund this course: (Tick as appropriate) Self-funding [ ]  Company paying [ ]  Other [ ]  If other, please specify:      Please indicate below, your preferred method of payment:  Debit Card [ ]  Credit Card [ ]   |

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| **SECTION 8 REFERENCE - PLEASE PROVIDE THE DETAILS FOR TWO REFEREES** |
| **Your referees must describe your suitability for this programme and be in a position to confirm your professional status or academic ability.** |
| **Reference 1.**  |
| Reference Type: Employer [ ]  Professional [ ]  Academic [ ]  Other [ ]  |
| How long have you known this person?       |
| Name:       |
| Profession:       |
| Address:       |
|  |
| Postcode/zip:       |
| Telephone:       |
| E-mail:       |
| **Reference 2.** |
| Reference Type: Employer [ ]  Professional [ ]  Academic [ ]  Other [ ]  |
| How long have you known this person?       |
| Name:       |
| Profession:       |
| Address:       |
| Postcode/zip:       |
| Telephone:       |
| E-mail:       |
| Please forward the reference forms to your referees and request completion at their earliest convenience. *These forms MUST be returned to you in PDF format and submitted with your application form and e-mailed to:* [PGDipTravelmed@rcpsg.ac.uk](file:///C%3A%5CUsers%5Chelenwa%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CZFCZNULL%5CPGDipTravelmed%40rcpsg.ac.uk)  |
| Please note, your application will not be processed until both of your references have been received by the College. |

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| **SECTION 9**  |
| On acceptance to this course, you are entitled to access materials from TRAVAX. Do you agree for the College to share your name and email address with TRAVAX for this purpose? [ ]  Yes [ ]  No  |
| If no, please state reason for this.  |

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| **SECTION 10 CHECKLIST** |
| Failure to complete any part of this application form may delay the application process. Please ensure you have ticked all of the boxes and included all relevant information before submitting your application. Please confirm all sections of the application form are completed [ ]   |

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| **SECTION 11 DECLARATION** |
| **DECLARATION** (To be signed by the candidate)I confirm, to the best of my knowledge that all the information given on this form is a true statement of fact.Signature of Applicant: …………………………………………………………………………….. Date ………………………………………………. |

**Please return your completed application to:**

Professional Development Certificate in Travel Medicine Course Administrator

Royal College of Physicians and Surgeons of Glasgow, 232 - 242 St Vincent Street, Glasgow, G2 5RJ

Tel: +44 (0)141 221 6072 Fax: +44 (0)141 221 1804 e-mail: [PGDipTravelmed@rcpsg.ac.uk](file:///C%3A%5CUsers%5Chelenwa%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CZFCZNULL%5CPGDipTravelmed%40rcpsg.ac.uk)  [www.rcpsg.ac.uk](http://www.rcpsg.ac.uk)

Registered Charity SC000847 A Charity Registered in Scotland

All Information we hold concerning you as an individual will be held and processed by the College strictly in accordance with the provisions of the Data Protection Act 1998. Such data will be used by the College to administer its relationship with you as an affiliate. We will not, without your consent, supply your name and address to any third party except where (1) such transfer is a necessary part of the activities that we undertake, including the provision of library services (if applicable) or (2) we are required to do so by operation of law. As an individual you have a right under the Data Protection Act 1998 to obtain information from us, including a description of the data that we hold on you. Should you have any enquiries about this right please contact Membership Services Administrator at the College.

*For official use only*:

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| **SECTION 12 APPLICATION PROCESS** |

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| **Complete Application:** (includes two references, English certificate and additional needs information, if applicable).Ready for review?[ ]  Yes [ ]  No  | **Application Reviewed by:** | **Outcome of Review**:  [ ]  Yes: Process application [ ]  No: Give reason below |
| **Staff Name:**  | **Staff Name:****Staff Name:** | **Reason:**  |
| **Please state if any further action(s) required:** (e.g. Additional Support Package and/or meeting required to discuss needs). |