

Joint Committee on Intercollegiate Examinations

Application for Appointment to the Panel of Examiners Paediatric Surgery

*Affix
Photo
Here*

Personal Details

GMC Number:

Title:

Surname:

First names:

Known as:

DOB:

Email address:

Home address:

Postcode:

Home telephone:

Home fax:

Present appointment

Post:

Date commenced:

Hospital:

Address:

Postcode:

Telephone no (direct):

Fax no:

Email address:

Secretary's name:

Secretary's No:

Preferred Correspondence Address (Please Tick)

Home

Hospital

☐
☐

FRCSEd

FRCSEng

FRCSGlas

FRCSI

College Affiliation:

☐
☐
☐
☐

Please ✓ below the area[s] in which you would be capable of examining:

Urology	<input type="checkbox"/>	Neonatal Surgery	<input type="checkbox"/>
Urology & Neonatal Urology	<input type="checkbox"/>	General & Gastro Intestinal Surgery	<input type="checkbox"/>
Oncology & Endocrine	<input type="checkbox"/>	Emergency Surgery & Trauma	<input type="checkbox"/>

Education

Qualifications obtained (include degrees, diplomas, professional examinations)

Exam/Qualification	Year	Exam/Qualification	Year

Previous Consultant/Senior Registrar appointments

Hospital / Medical School	Position held	Dates	
		From	To

Membership of Other Examination Boards, Responsibilities for Education and Training
Previous and Current Examining Experience must be listed

Professional Body	Subject	Dates	
		From	To

General Experience

Please give details of further experience that may be relevance to the post of examiner

Please list below your three most recent publications

I confirm that I have undergone an Equal Opportunities and Diversity Training Course.

Course attended:

Date Course attended:

- ☐ I confirm that I understand that the procedure of appointment is by submission to the Intercollegiate Board in Paediatric Surgery. Subject to acceptance by the Board, my name will be forwarded to the Joint Committee on Intercollegiate Examinations for ratification. If appointed, I am prepared to serve on the Panel of Examiners for a period of five years from the date of my first examination. I have read and understood the further particulars pertaining to Appointment to the Panel of Examiners and am willing to commit to the professional conduct and development of the examination as well as the assessment, training and development as an examiner and will provide the time necessary to honour these commitments.

Signed:

Date:

Please return completed form to:

**Joint Committee on Intercollegiate Examinations
The Royal College of Surgeons of Edinburgh
Nicolson Street
Edinburgh
EH8 9DW
Tel: 0131 662 9222
www.jcie.org.uk**

For official use only

Date Received	Board	Approved (circle appropriately): Yes / No	Observe Exam	1st Exam	Database Input [Initials/Date]

Structured Reference A

from the Chief Executive or Medical Director

Supporting an Application to the Panel of Examiners
Intercollegiate Specialty Board in
Paediatric Surgery

Name of Applicant [in CAPS]	<input type="text"/>
Full Name of Referee [in CAPS]	<input type="text"/>
Post	Please choose as appropriate <input type="text"/>
Name of Trust	<input type="text"/>
Full Postal Address	<input type="text"/>
Telephone Number	<input type="text"/>
Declaration	<p>I confirm that the above Consultant:</p> <p><input type="checkbox"/> has the approval of the Hospital Trust to commit the time necessary to undertake this important educational role [as detailed in the Eligibility Criterion 7)]</p> <p><input type="checkbox"/> has a commitment to continuing professional development and research (inc publications) with up to date specialist knowledge. [as detailed in the Person Specification 3)].</p>
Signature
Name in Caps	<input type="text"/>
Date	<input type="text"/>

Structured Reference B

from the Chairman Specialist Training Committee or Training Programme Director

Supporting an Application to the Panel of Examiners
Intercollegiate Specialty Board in
Paediatric Surgery

Name of Applicant [in CAPS]	<input type="text"/>
Full Name of Referee [in CAPS]	<input type="text"/>
Post	Please choose as appropriate <input type="text"/>
Full Postal Address	<input type="text"/>
Telephone Number	<input type="text"/>
Declaration	<p>I confirm that the above Consultant:</p> <ul style="list-style-type: none"><input type="checkbox"/> would be able to demonstrate a policy of courtesy, fairness and non discrimination<input type="checkbox"/> has high professional standards and a commitment to the teaching and development of higher surgical trainees<input type="checkbox"/> has an enthusiasm for, competence in and loyalty to the surgical profession [as detailed in the Person Specification 1), 2) and 4)]
Signature
Name in Caps	<input type="text"/>
Date	<input type="text"/>