**AHP Return to Practice**

**Request for Supervised Practice Form**

Instructions: please record responses in the white cells below and email this form to the NHS Board AHP Return to Practice Contact to initiate your request to undertake supervised practice.

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| **Returnee Name**  |  | **Date of application 00/00/00** |  |
| **Profession** |  | **Email address** |  |
| **Preferred NHS Board to undertake supervised practice** |  | **Have you been registered with the HCPC or HPC before? Yes/No** |  |
| **When did you leave the HCPC/ HPC register? Enter date/ year or Not Applicable** |  | **Are you subject to any Fitness to Practise proceedings with the HCPC? Yes/ No** |  |
| **Are you currently suspended from the HCPC register? Yes/No** |  | **Preferred days of week to attend supervised practice.** |  |
| **Requested hours of supervised practice per week e.g. 10, 37 hrs**  |  | **Number of days of supervised practice requested e.g. 10, 30, 60** |  |
| **Name of education institution that you graduated from, and country.** |  |
| **Years since graduating** |  |
| **Previous Professional Experience** |  |
| **Preferred Supervised practice site(s) (if known)** |  |
| **Preferred speciality / setting for supervised practice** |  |
| **Preferred service user group you wish to gain experience with e.g. adults, children.** |  |