

**Membership Application Form**

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| **Name:** |  |
| **Surgical Specialty** |  |
| **Year of Completion of Surgical Training** |  |
| **Year of Appointment to Current role** |  |
| **Medical Council Membership Number** |  |
| **Have you completed a recognised train the trainer course** |  |
| **Any further information you would like include that would support your application for membership of the Faculty** |  |

*For office use only:*

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| Date application received |  |
| Specialty Training Committee meeting date for consideration |  |
| Membership proposal accepted | Yes or No |
| Communication to candidate |  |