



Jeelani Drabu Palliative Care online course **application form**

The information that you provide may be used in the compilation of data and reports, but the source will be kept anonymous. Please type or complete legibly using **BLOCK CAPITALS**. Use additional blank pages if necessary.

Personal details

Last name/family name

Forename(s)/first name(s)

Gender

Telephone number (with country code)

Correspondence address

Email

Qualification details

Name and address of university/medical school for your **primary medical / nursing** qualification

Title of qualification

Date started (dd/mm/yy)

Date finished (dd/mm/yy)

Employment history

Current post

Name and address of employing hospital/institution

Job title and grade

Date started

Specialty interest

Application form

Previous appointments

Please list your past medical appointments. You should enter all dates in full in the additional sheet if necessary.

From (mm/yy)

to (mm/yy)

Grade

Specialty

Hospital

What do you hope to gain from attending this course?

What impact would you hope that such a programme will have on your healthcare provision?

(minimum 250 words, maximum 500)?

Do you have any experience of palliative care in clinical practice?

If so, please provide details. (maximum 200 words)

Application form

How do you think palliative care will apply to your current practice? (maximum 250 words)

Signature

I confirm that the information I have provided in my application is correct and true. I understand that any false declaration in any part of the application may result in a refusal of the application. I understand that the Royal College of Physicians (RCP) reserves the right to refuse my application, or request further documentation and evidence to support my application if it feels it is necessary. I understand that the RCP retains the right to withdraw the offer of a place in the training if any information provided in my application is found to be false or misleading at a later date. I consent to the RCP processing and retaining the personal information contained in this application in line with its registration under the Data Protection Act.

Signature*

Date

*Electronic signatures are acceptable, as well as typing your name in the signature space.

Please return this completed form electronically to global@rcp.ac.uk by 30 September 2025.

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Royal College
of Physicians

Global

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From (mm/yy) to (mm/yy)

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Hospital

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