

London S12/AC Approvals Panel

Continuing Professional Development (CPD) Form

Practitioners must provide CPD evidence in order to gain either initial or renewal approval for Approved Clinician purposes to meet the standards set out in the Instructions from the Secretary of State for these functions.

In order for London Approvals Panel to accept CPD sign-off, the content of this form must meet the minimum standards set out below.

It is the practitioner's responsibility to:

- participate in CPD and provide the appropriate evidence
- demonstrate that the practitioners CPD activities are a mixture of learning activities relevant to current or future practice
- seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
- seek to ensure that their CPD benefits the service user

London Approvals Panel encourages applicants to use this form which should be completed to ensure a recognised format is adhered to.

CPD Activity Log

| | |
|---|------------------------|
| Full Name | |
| Professional Registration Number | GMC/HCPC/NMC/SWE/Other |
| Date From: | DD/MM/YYYY |
| Date To: | DD/MM/YYYY |

| Date | CPD Activity | Clinical hours (<u>minimum</u> 30 hours) | Academic (hours) | Professional (hours) |
|-------------|---------------------|---|-----------------------------|---------------------------------|
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| Total Hours of CPD Activity [Total Hours of CPD Activity 50 hours completed in the past 12 months] | | | | |

- For all self-accredited activities, I confirm that the activities have been educationally valuable, and I have been provided with appropriate evidence of attendance and reflection.
- I confirm that the number of hours claimed are appropriate for each CPD activity.
- I confirm that I have accumulated the specified hours of activity in the period stated and that this is sufficient evidence of CPD as per the standards of my profession.

| Applicant's Name | Signature | Date |
|------------------|-----------|------|
| | | |

FOR PSYCHIATRISTS USE ONLY: Peer Group Members Declaration

I confirm that the practitioner has accumulated the specified hours activity in the period stated and that this is sufficient evidence of CPD as per the Royal College of Psychiatrists or relevant professional body standards.

| Name | Professional GMC Registration no. | Signature | Date |
|------|-----------------------------------|-----------|------|
| | | | |

| Name | Professional GMC Registration no. | Signature | Date |
|------|-----------------------------------|-----------|------|
| | | | |

| Name | Professional GMC Registration no. | Signature | Date |
|------|-----------------------------------|-----------|------|
| | | | |

FOR MPAC USE ONLY: To be completed by a Clinical Director (or equivalent) who hold Line Management responsibilities

| | |
|--|--|
| Name | |
| Professional Registration Number (/HCPC/NMC/SWE) | |
| Employing organisation | |
| Post held | |
| Professional address | |

Do you hold an Approved Clinician status? Yes /No

Do you hold line management responsibilities? Yes/No

Signature *: **Date** :