

Certificate of Readiness to Enter Specialty Training 2024 (Last Updated 2023)

Instructions to applicants:

1. This certificate can only be signed by a Consultant or equivalent. For the purposes of this documentation, Consultant includes General Practitioners, Clinical Directors, Medical Superintendents, Academic Professors, and locum Consultants with a CCT/CESR and who are on the specialist register.
2. Consultants are only eligible to sign this certificate if they have worked with you for a minimum continuous period of three months whole-time equivalent wholly within the 3.5 years prior to the advertised post start date for which you are applying. Please note clinical attachments and observer posts CANNOT be used to evidence this requirement. Please ensure you have read the Evidence of Foundation Competence - Applicant Guide available via the Oriel resource bank <https://www.oriel.nhs.uk/Web/>
3. If your signatory is registered with any medical regulatory authority other than the GMC, then you should also make sure they submit **current** evidence of their registration with that authority. A certified translation should be included if this is not in English. Historic registration with the GMC will not be accepted. *Failure to provide this will result in you, the applicant, being rejected.*
4. You should not use a signatory with whom you have a close personal relationship.
5. You must be rated as demonstrated for each and every professional capability listed on this certificate. If you cannot demonstrate that you have achieved all your professional capabilities in one post, you may submit additional evidence to the signatory who, if they agree that it demonstrates capability may accept it in lieu of direct observation. If you cannot demonstrate each and every professional capability, you will not be eligible for Specialty Training at ST1 or CT1 level. Should your signatory select 'unable to confirm' for any of the competencies, you will not be eligible for Specialty Training.
6. If you have ever started but not satisfactorily completed a UKFPO-appointed 2-year Foundation programme or FY2 standalone post, then you should **not** use this form. Instead, you should approach the Foundation School Director where your previous training took place and either request to return to complete that training or provide such evidence as they request then ask the Dean of that area to complete and sign the proforma available on the resource bank.
7. The certificate MUST be complete in every detail, including details about the person completing it for you. Incomplete certificates may lead to your application being deemed ineligible for that recruitment round. It is strongly recommended that you check the form after your signatory has completed it using the attached checklist.
8. If the certificate is digitally signed, an email from the signatory's work email address, confirming authenticity, should be scanned and uploaded with the certificate.
9. Please see Oriel resource bank for further information on completion of this form <https://www.oriel.nhs.uk/Web/>.
10. You must then scan, upload and attach it (as **one** single document) to your application form before submission. It is your sole responsibility to ensure that the CREST form is satisfactorily completed **in full** prior to submission.
11. Because of changes to the process, **only the 2024 version of this form will be accepted.**
12. The form will remain valid for future rounds of application provided that those conditions still apply to the new intended start date.

Please note that making a false declaration in this form will result in any offer of a training post being withdrawn and consideration being given to you being referred to the GMC

Applicant Name	To be completed by the applicant		
Applicant GMC No	To be completed by the applicant		
Posts: Please complete the table below to document the posts from which you have used evidence to complete this form.			
Role/Job Title	Employer Name	Post Start Date	Post End Date
	Applicant to detail all posts from which evidence has been taken for this form		
Applicant declaration	I confirm that I have attained all of the professional capabilities signed off in this form and that I have worked for the consultant who has completed this certificate for a minimum continuous period of three months whole time equivalent within the three and a half years prior to the advertised post start date for which I am applying.		
Applicant declaration	I can confirm I follow the guidance in Good Medical Practice (or equivalent) relating to prescribing for self, friends or family		
Applicant declaration	I confirm that I am not related to, or in a relationship with the signatory of this form		
Applicant Signature	To be signed by the applicant		

		Please select one box for each capability. Do not group capabilities together.		
Section 1: An accountable, capable and compassionate doctor [*please note: if you are relying on evidence received rather than personally witnessing demonstration of these capabilities, please also complete the evidence section on page 5 detailing this evidence]		Personally witnessed	Evidence received*	Unable to confirm
1.1 Clinical assessment	Assess patient needs in a variety of clinical settings including acute, non-acute and community			
1.2 Clinical prioritisation	Recognise and, where appropriate, initiate u			
1.3 Holistic planning	Diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient			
1.4 Communication and care	Provide clear explanations to patients/carers, agree a plan and deliver healthcare advice and treatment where appropriate			
Verifying consultant's signature confirming details above: Must be signed				
Applicants name:	Must be completed	Date of completion:	Must be completed	

Tick one box per professional capability



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		Please select one box for each capability. Do not group capabilities together.		
Section 1 (continued): An accountable, capable and compassionate doctor [*please note: if you are relying on evidence received rather than personally witnessing demonstration of these capabilities, please also complete the evidence section on page 5 detailing this evidence]		Personally witnessed	Evidence received*	Unable to confirm
1.5 Continuity of care	Contribute to safe ongoing care, both in and out of hours			
Section 2: A valuable member of healthcare workforce				
2.1 Sharing the vision	Work confidently within the multi professional team and, where appropriate, guide the team to deliver a consistently high standard of patient care based on sound ethical principles			
2.2 Fitness for practise	Develop the skills necessary to manage own personal wellbeing			
2.3 Upholding values	Act as a responsible employee, including speaking up when others do not act in accordance with the values of the healthcare system			
2.4 Quality improvement	Take an active part in processes to improve the quality of care			
2.5 Teaching the teacher	Teach and present effectively			
Section 3: A professional, responsible for their own practice and portfolio development				
3.1 Ethics and law	Demonstrate professional practice in line with statutory requirements, through development of a professional portfolio			
3.2 Continuing professional development	Develop practice, including the acquisition of new knowledge and skills through experiential learning; acceptance of feedback and, if necessary, remediation; reading and, if appropriate through research			
3.3 Understanding medicine	Understand the breadth of medical practice and plan a career			
Verifying consultant's signature confirming details above: Must be signed				
Applicants name:	Must be completed	Date of completion:	Must be completed	

******Please make sure that you now sign the declaration on the next page******

Declaration by person signing this certificate:

REMINDER: We would wish to remind signatories of their professional responsibilities under the General Medical Council's guidance "Good Medical Practice" (paragraph 71) which states that "*you must do your best to make sure that any documents you write or you sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents*". **Failure to do so renders you, the signatory, at risk of being referred to your regulatory authority (the GMC or equivalent).** Patient Safety must remain your primary concern.

Your name:	Must be completed
Professional status :	Must be completed
Current post:	Must be completed
Dates you supervised the applicant:	From: Must be completed To: Must be completed
Address for correspondence:	Must be completed
Email address:	Must be completed
Your UK GMC Number:	Must be completed

If you are not registered with the UK GMC, please give: **Name of your registering body: Must be completed**
Your Registration Number: Must be completed
Please provide the applicant with photocopy evidence of your current registration with that body to this certificate. A certified translation should be included if this is not in English. Historic registration with the GMC will not be accepted. *Failure to provide this will result in the applicant, being rejected.*

For all signatories (please complete sections A to D): All below tick boxes must be completed

- A) I confirm that I have viewed the official Foundation Programme website (<https://foundationprogramme.nhs.uk/curriculum/>) and that I am aware of the standards expected of UK Foundation Programme year 2 doctors.
- B) I confirm that the doctor named above has worked for me prior to their application submission and continuously for a minimum of three months whole time equivalent within the 3½ years prior to the advertised start date. I am aware that clinical attachments and observer posts cannot be used to evidence this requirement and have read the Evidence of Foundation Competence 2024 – Signatories' Guide available via the Oriel resource bank <https://www.oriel.nhs.uk/Web/>
- C) I can confirm that I have observed the doctor named above demonstrate all of the listed competences **OR** where I have not personally observed them, I have received alternative evidence that I know to be reliable from a colleague (if the colleague is a trainee, they must be working satisfactorily at ST5 or above). **I have listed those providing evidence on the next page.**
- D) I confirm that I am not related to, or in a relationship with the applicant

NB: *This form is invalid unless boxes A, B C and D above are checked.*

Verifying consultant's signature confirming details above: Must be signed

Applicants name:	Must be completed	Date of completion:	Must be completed
HOSPITAL STAMP If not available, please attached a signed compliment slip and give hospital name and website address	Must be stamped		

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List of people whose evidence I have used in signing this certificate: Where I have not personally observed them, I have received alternative evidence that I know to be reliable from a colleague, as detailed below (if the colleague is a trainee, they must be working satisfactorily at ST5 or above). Please ensure that you enter the section/s of the certificate where each individual has observed outcomes **Please note that, as part of the verification process, the recruiting process may contact these people to verify and confirm that they have provided you with such evidence:**

*Please note: this section is only required to be completed if the column 'evidence received' has been used for a capability.

Section or capabilities witnessed: Must be completed in full where evidence from others is used to demonstrate competence

Their name:			
Professional status :			
Work Address:			
Email address:			
Dates they supervised the applicant	From:		To:
Section or capabilities witnessed:			
Their name:			
Professional status :			
Work Address:			
Email address:			
Dates they supervised the applicant	From:		To:
Section or capabilities witnessed:			
Their name:			
Professional status :			
Work Address:			
Email address:			
Dates they supervised the applicant	From:		To:
Section or capabilities witnessed:			
Their name:			
Professional status :			
Work Address:			
Email address:			
Dates they supervised the applicant	From:		To:
Verifying consultant's signature confirming the above:			Must be signed
Applicants name:	Must be completed	Date of completion:	Must be completed