**Application for New CPIP Trainer**

New trainers must meet **ALL** of the following criteria. It is the responsibility of the Clinical Lead/Head of Department to support this application confirming that these criteria have been met.

On completion the form should be scanned and returned to the CPIP Regional Representative (see APCP website, CPIP page for contact details).

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| --- | --- |
| Name of Trainer Applicant: |  |
| Employing NHS Trust: |  |
| Trainer applicant email address: |  |

|  |  |
| --- | --- |
|  | Yes/No |
| HPC registered Physiotherapist |  |
| Agree to deliver not for profit training to staff |  |
| Identified need for additional trainers within the Department/Trust |  |
| Completing regular consistent CPIP assessments, with a minimum of 10 assessments per year |  |
| ***Please state average number being completed each year:*** |  |
| Completing CPIP assessments for a minimum of 2 years |  |
| ***Please state number of years:*** |  |
| Minimum of 3 years experience of working with children and young people with Cerebral Palsy |  |
| ***Please state number of years:*** |  |
| Proven strong clinical reasoning skills working with children and young people with cerebral palsy |  |
| Proven strong time management and organisational skills |  |
| Proven strong presentation skills |  |
| Demonstrate continued competency in CPIP assessments |  |
| Commitment to engage in a minimum of one CPIP related activity outside your trust each year and maintain evidence of your CPD relating to CPIP. |  |
| Enthusiasm/interest in the role of CPIP trainer |  |
| Commitment to feed into regional group and Regional CPIP Rep on updates in your area |  |
| Maintain an accurate, updated database of trainees and their ongoing competencies |  |

I confirm that I meet all of the above criteria and would like to be considered for the role of CPIP Trainer

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| --- | --- |
| Signature: | Date: |

As Clinical Lead/Head of Department, I confirm that the applicant meets all of the above criteria and I am in support of their application to take on the role of CPIP Trainer

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| --- | --- |
| Signature: | Date: |
| Print Name: | |
| Job Title: | |
| Email Address: | |

For administration Purposes (to be completed by Regional rep):

|  |  |
| --- | --- |
| Application Approved: | Yes/No |
| Reasons for any refusal |  |
| Trainer Number issued: |  |
| Date email sent to Applicant and Supporting Manager including database spreadsheet, trainer number, links/access to training materials: |  |
| Date trainer added to Regional trainer database: |  |