Higher Training Scheme
Higher Certificate of Clinical Competence

CLINICAL

Registration Form

Which module do you want to register for ? _

SURNAME		DATE OF BIRTH	
FORENAME		BAA MEMBERSHIP NO.	
TITLE (please circle)	Dr / Mr / Ms / Mrs / Miss	REGISTRATION STATUS (please circle)	Registered Clinical Scientist / Registered Clinical Physiologist / Pre-registration

WORK ADDRESS	
DEPT.	
HOSP/INSTITUTE	
ROAD	
TOWN	
COUNTY	
POSTCODE	
TELEPHONE	
FAX	
EMAIL	

ADDRESS FOR INVOICING (IF DIFFERENT)

Current Post

POST HELD	
DATE COMMENCED	
GRADE	
LINE MANAGER	

Qualifications gained since leaving school
(HNC / HND / BSc / MSc / BAAT part 1 & 2 / CAC etc):

AWARD	SUBJECT	DATE AWARDED	INSTITUTION / AWARDING BODY

Demonstration that theoretical pre-requisites have been met

Please confirm how each of the pre-requisite theoretical knowledge needed for the particular HCCC module has been gained. The details of this is given on the BAA website. If appropriate, give details of short courses and M-level modules if not included in the above table. Photocopies of course attendance certificates or awards should be enclosed if using in evidence.

No.	Theoretical knowledge required and evidence – please include additional evidence / certificates as required
1	
2	
3	
4	
5	
6	
7	
8	
9	
10.	

Overall supervisor:

SURNAME		GRADE	
FORENAME		BAA MEMBERSHIP NO.	
TITLE (please circle)	Dr / Mr / Ms / Mrs / Miss	REGISTRATION STATUS (please circle,)	Registered Clinical Scientist / Registered Clinical Physiologist / Pre-registration

WORK ADDRESS	
DEPT.	
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ROAD	
TOWN	
COUNTY	
POSTCODE	
TELEPHONE	
FAX	
EMAIL	

Details of staff providing clinical supervision (include overall supervisor if appropriate):

Name	Grade	How long has this individual been working in this specialist area?	How many sessions per week does this individual do in this specialist area?	Signed and dated confirmation from Head of Department that this individual either hold the HCCC or is at an equivalent level of competence

Centre accreditation:
Date accreditation was awarded _ _ _ _ _ _ _ _ _ _ (this has to be within five years)

Details of any changes in facilities, equipment, activity and availability of supervision since accreditation was awarded.

I confirm that the information on this form is correct to the best of my knowledge. If information is found to be subsequently incorrect, and this is not highlighted to the HTS co-ordinator, registration will be cancelled and registration fees will be forfeited.

Signed (Candidate)	Date
Signed (Head of Department)	Date

On completion of the registration form - please send directly to the registration co-ordinator at the address given on the BAA website (HTS section). Confirmation of receipt of the form will be sent by the registration co-ordinator. Following confirmation, you will receive an invoice for the amount owed directly from the BAA office. Payment will need to be received prior to the start of the module.

Current fees are given on the BAA website. Please note - it is only the registration fee that will be invoiced, not the assessment fee.

Please ensure all parts of this form are complete and enclosed, otherwise registration cannot take place.

For office use only

Date received		Notes
Date assessed		
Date letter/ email sent		
Outcome	Agreed / Refer	