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SECTION B - TO BE COMPLETED BY HOSPITAL ADMINISTRATION ONLY

HOSPITAL IN WHICH DOCTOR WILL BE PRACTISING	
+ ° SPECIALTY IN WHICH DOCTOR WILL BE PRACTISING:	
+ ° DATE APPOINTMENT WILL COMMENCE:	
+ ° DATE APPOINTMENT WILL TERMINATE:	
° APPROVED TRAINING POST NUMBER:	
NAME(S) OF SUPERVISING CONSULTANT(S):	

HOSPITAL IN WHICH DOCTOR WILL BE PRACTISING	
+ ° SPECIALTY IN WHICH DOCTOR WILL BE PRACTISING:	
+ ° DATE (AND TIME IF APPLICABLE) APPOINTMENT WILL COMMENCE:	
+ ° DATE (AND TIME IF APPLICABLE) APPOINTMENT WILL TERMINATE:	
° APPROVED TRAINING POST NUMBER:	
NAME(S) OF SUPERVISING CONSULTANT(S):	

Signed: _____ Date: _____
(on behalf of hospital administration)

Name (in block capitals):

Liaison Telephone No:

<p>HOSPITAL STAMP</p>
