**Bank Request Form (Junior)**

Roster gaps: Following Junior Medic roster sign off, gaps in rosters held centrally will be shared for approval and sent to Bank. For those rosters not held centrally this form **must** be completed for all Bank requests for Junior Medics and submitted to the Temporary Staffing Team with appropriate Clinical Director **and** Head of Operations sign off. 

Additional requirements:- Requests outside of your roster template (additional shifts) should only be submitted in exceptional circumstances and if you consider that there is a need for additional medical cover in order to maintain patient safety (e.g., cover required for additional footprint). All additional requests **must** be signed off by the appropriate Divisional Medical Director **and** Divisional Director of Operations for the requesting Division and the form submitted to the Temporary Staffing Team.  

Out of Hours: In exceptional circumstances retrospective forms will be accepted for emergency out of hours requests only. **These MUST be signed off by Operational (Silver) Command on call.**It should then retrospectively be signed by both site Divisional Medical Director and site Director of Operations and submitted to the Temporary Staffing Team in order to maintain governance around the role.

**Please provide the information below in its entirety and return to medical.tempstaff@liverpoolft.nhs.uk**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Shift** | **Request Reason** | **Area/ Department** | **Site** | **Required Grade** | **Shift Times** | **Named Medic (if known)** | **On Call (Y/N)** | **Resident (Y/N)** | **Escalation Required?** |
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| **Assessment** | | |
| **Do you determine that there is likely to be a risk to patient safety without this additional resource? (Y/N)** | **Y** | **N** |
| **What alternatives to bank/additional duty have you considered? Why are these not appropriate?** |  | |
| **What other roles could be utilised to cover this duty?** |  | |
| **If this shift is due to be worked in less than 48 hours, is an escalated rate required?** | **Y** | **N** |
| **Requester/Approval Details** | | |
| **Requester Name** |  | |
| **Department** |  | |
| **Site** |  | |
| **Cost Centre** |  | |
| **Division** |  | |
| **Clinical Director Name** |  | |
| **Clinical Director Signature** |  | |
| **Divisional HooP Name** |  | |
| **Divisional HooP Signature** |  | |
| **Date** |  | |
| **Additional Requirement Approval – only required for additional duties requested in exceptional circumstances** | | |
| **Divisional Director of Ops Name** |  | |
| **Divisional Director of Ops Signature** |  | |
| **Divisional Medical Director Name** |  | |
| **Divisional Medical Director Signature** |  | |
| **Escalation Approval – should only be given if shift has a lead time of < 2 days** | | |
| **Site Director of Ops Name** |  | |
| **Site Director of Ops Signature** |  | |
| **Site Medical Director Name** |  | |
| **Site Medical Director Signature** |  | |