|  |  |  |
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| RACP2016_OL | | **Training Committee in Community Child Health** |
| **Application for Prospective Approval of Advanced Training** | | |
| **Important Information** | | |
| This application form is for use by Advanced Trainees and Fellows who intend to undertake training. If you intend to interrupt your training, take longer leave or withdraw from training you will need to complete a different application form which is available [here](https://www.racp.edu.au/trainees/flexible-training-options/interrupting-or-withdrawing-from-training).  You are advised to retain a copy of the completed form for your records. **Before you complete this form –** Please ensure you have read and familiarised yourself with the relevant [Advanced Training Program Requirements Handbooks](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy).  Applications can span multiple training years but may not exceed 12 months per application | | |
| **Closing Dates** | | |
| **15 February** for approval of the first half or the entire training year  **31 August** for approval of the second half of the training year | | |
| **Notification of Approval** | | |
| Once your application has been considered by the nominated supervising committee(s), you will be notified of the decision in writing. Whenever possible, this advice will be sent *within six weeks* of the application deadline. The committee will approve the application, decline the application or defer the decision pending provision of further information.  Applications submitted after the published deadlines will attract a late fee. Consideration of applications submitted after the deadline may be delayed. Late applications will not be accepted from one month after the published deadline. If your application is submitted late, you must attach an [Application for Consideration of Exceptional Circumstances](https://www.racp.edu.au/trainees/flexible-training-options/exceptional-circumstances) outlining the reasons for the delay. | | |
| **Payment of Training Fees** | | |
| You will be invoiced for your training **once your training has been approved**. You will be notified once an approval decision has been made and directed to [MyRACP](https://my.racp.edu.au/), where you will be able to view details of your outstanding fees and past payments.  A schedule of current training fees is available [here](https://www.racp.edu.au/become-a-physician/membership-fees). For queries or support regarding your training fees, please contact a Finance Officer by email [Accounts.Receivable@racp.edu.au](mailto:Accounts.Receivable@racp.edu.au) or call (+61) 2 9256 9629 or (+61) 2 9256 9621 to discuss the matter. NZ contact details – [racp@racp.org.nz](mailto:racp@racp.org.nz) | | |
| **Enquiries & Application Submission** | | |
| **Enquiries** | **Submission Process** | |
| Phone: +61 2 8247 6231  Email: [CommunityChildHealth@racp.edu.au](mailto:CommunityChildHealth@racp.edu.au) | Please ensure you have saved a copy for your records and email an electronically saved or clearly scanned copy to [Communitychildhealth@racp.edu.au](mailto:Communitychildhealth@racp.edu.au)(photos will not be accepted). Please CC in your nominated supervisors for their records. Hard copy applications are not required. | |

**Training Committee in Community Child Health**

**Application for Prospective Approval of Advanced Training**

**This application may cover a single term/rotation or more than one term/rotation occurring in the year.**

**1. PERSONAL DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Trainee | |  | |  | | |
|  | | SURNAME / FAMILY NAME | | GIVEN / FIRST NAME(S) | | |
| Contact E-mail | |  | | | | |
| **NB:** The College will use email as the primary method to communicate with you throughout your Advanced Training. Please ensure that you can receive e-mail from [CommunityChildHealth@racp.edu.au](mailto:CommunityChildHealth@racp.edu.au) by adding this address to your address book and/or safe senders list.  Any updates to contact details should be made through <https://my.racp.edu.au/>. | | | | | | |
|  | Please tick the following box if you wish to be removed from the contact list provided to the Australian and New Zealand Society of Palliative Medicine (ANZSPM) | | | | | |
|  |  | | | | | |
| Member ID No (MIN) *If you don’t know your MIN, leave it blank.* | | |  | | |
|  | | |  | |  |
| **Are you of Aboriginal, Torres Strait Islander or Māori origin?**  *For persons of both Aboriginal and Torres Strait Islander origin, mark both ‘yes’ boxes*. | | | No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, Māori  Māori iwi affiliation | | |

**2. TRAINEE DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region:** |  | Australia |  | New Zealand |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Division:** |  | Adult Medicine |  | Paediatrics & Child Health |
|  |  | Chapter |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Training Status:** |  | Advanced Training |  | Post FRACP Training  (have been admitted as a Fellow of RACP) |

**3. SUPERVISION BY TWO COMMITTEES – DUAL TRAINING**

*If you are a dual trainee please complete this section.*

*Please read the training guidelines for each specialty before applying to consider if this period of training may be eligible for both specialties. You should only submit* ***one application*** *to the College – a copy will be forwarded to each committee. You are only required to pay* ***one annual fee*** *for Advanced Training.*

*I intend on completing multiple training programs and wish to have this/these terms of training considered for approval by two advanced training committees.*

|  |  |  |  |
| --- | --- | --- | --- |
| Primary committee  (most relevant to enclosed training rotations) |  | Secondary committee  (other committee to be made aware of rotation details) |  |

**4. DETAILS OF TRAINING PROGRAM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year of Advanced Training: |  |  | | | |
|  | | | | | |
| Employing Health Service/Institution: |  | | | |
|  | | | | | |
| Number of terms (or rotations) indicated on this application: | | |  |  | |

TIP: If you are in one position for the whole period of training indicated on this form, please provide further details under Term 1 only. *One term should be allotted to a single rotation to a different site*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TERM No.** | | | | 1 | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | Full time | or |  | | | Part time | | | | | If part time, percentage of full time training: | | | | % | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Duration of this training term (months): | | | | | | | | |  | | Commencing: | | |  | Ending: |  | |
|  | | | | | | | | |  | | |  | | | |  | | | |
| **Approval sought for:** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | 1. CCH Educational Tutorial Series Attendance | | | | | | | | | | | |
|  | | 2. Core Clinical – Developmental and Behavioural Paediatrics | | | | | | | | | | | |
|  | | 3. Core Clinical – Community-based Multidisciplinary Paediatrics | | | | | | | | | | | |
|  | | 4. Core Clinical – Child Protection | | | | | | | | | | | |
|  | | 5. Core Clinical – Social Paediatrics | | | | | | | | | | | |
|  | | 6. Child Population Health Activities | | | | | | | | | | | |
|  | | 7. Non-core Community Child Health training | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | |
| Post or position: | | | | |  | | | | | | | | | | | | | | |
| Hospital/Institution: | | | | |  | | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | |
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| Training in the following subspecialty: | | | | |  | | | | | | | | | | | | | | |
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| Describe the clinical experience to be obtained in this proposed term: | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Appointment in:**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |

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| **Clinical activities and responsibilities:** | | | | | |
| Hours spent in clinical activities per week | | |  | Hours expressed as a percentage of total hours per week | % |
|  | | | | | |
| Brief outline of work in Child Development | |  | | | |
|  | | | | | |
| Brief outline of work in Behavioural Problems | |  | | | |
|  | | | | | |
| Brief outline of Community-based multidisciplinary work | |  | | | |
|  | | | | | |
| Brief outline of work in Child Protection | |  | | | |
|  | | | | | |
| Brief outline of other clinical work | |  | | | |
| **Non- Clinical activities and responsibilities:** | | | | | |
| Hours spent in non clinical activities per week | | |  | Hours expressed as a percentage of total hours per week | % |
|  | | | | | |
| Brief outline of work in Population medicine: | |  | | | |
|  | | | | | |
| Brief outline of work in Teaching in the Community/ Community Work: | |  | | | |
|  | | | | | |
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| Brief outline Postgraduate Course work: | |  | | | |
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| Brief outline of other Research: | |  | | | |
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| **Weekly Timetable** | | | |  | | |
| **TERM/S** | | 1 | |
| Please provide a **detailed** weekly timetable for your position, outlining what you will be doing each day, and how you will be supervised. Please provide an explanation of what percentage of the daily activities related to the Community Child Health requirements, e.g. Developmental – behavioural paediatrics, Child protection or Child Population Health activities (*please attach a detailed timetable if the detail does not fit in the below timetable format*). | | | | | | | | | | |
|  | Monday | | | | Tuesday | | Wednesday | Thursday | Friday |
| am |  | | | |  | |  |  |  |
| pm |  | | | |  | |  |  |  |

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| **TERM No.** | | | | 2 (if applicable) | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | Full time | or |  | | | Part time | | | | | | If part time, percentage of full time training: | | | | % | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Duration of this training term (months): | | | | | | | | |  | | | Commencing: | | |  | Ending: |  | | |
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| **Approval sought for:** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | 1. CCH Educational Tutorial Series Attendance | | | | | | | | | | | | | |
|  | | 2. Core Clinical – Developmental and Behavioural Paediatrics | | | | | | | | | | | | | |
|  | | 3. Core Clinical – Community-based Multidisciplinary Paediatrics | | | | | | | | | | | | | |
|  | | 4. Core Clinical – Child Protection | | | | | | | | | | | | | |
|  | | 5. Core Clinical – Social Paediatrics | | | | | | | | | | | | | |
|  | | 6. Child Population Health Activities | | | | | | | | | | | | | |
|  | | 7. Non-core Community Child Health training | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | |
| Post or position: | | | | |  | | | | | | | | | | | | | | | | |
| Hospital/Institution: | | | | |  | | | | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | |
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| Training in the following subspecialty: | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | |
| Describe the clinical experience to be obtained in this proposed term: | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Appointment in:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Clinical activities and responsibilities: | | | | | | | | | | | | | | | | | | | | | |
| Hours spent in clinical activities per week | | | | | | | | | |  | | | Hours expressed as a percentage of total hours per week | | | | | % | | | |
| Brief outline of work in Child Development | | | |  | | | | | | | | | | | | | | | | | |
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| Brief outline of work in Behavioural Problems | | | |  | | | | | | | | | | | | | | | | | |
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| Brief outline of Community-based multidisciplinary work | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Brief outline of work in Child Protection | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Brief outline of other clinical work | | | |  | | | | | | | | | | | | | | | | | |
| **Non- Clinical activities and responsibilities:** | | | | | | | | | | | | | | | | | | | | | |
| Hours spent in clinical activities per week | | | | | | | | | |  | | | Hours expressed as a percentage of total hours per week | | | | | % | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Brief outline of work in Population medicine: | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Brief outline of work in Teaching in the Community/ Community Work: | | | |  | | | | | | | | | | | | | | | | | |
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| Brief outline Postgraduate Course work: | | | |  | | | | | | | | | | | | | | | | | |
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| Brief outline of other Research: | | | |  | | | | | | | | | | | | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- |
| **Weekly Timetable** | | | |  | | |
| **TERM/S** | | 2 | |
| Please provide a **detailed** weekly timetable for your position, outlining what you will be doing each day, and how you will be supervised. Please provide an explanation of what percentage of the daily activities related to the Community Child Health requirements, e.g. Developmental – behavioural paediatrics, Child protection or Child Population Health activities (*please attach a detailed timetable if the detail does not fit in the below timetable format*). | | | | | | | | | | |
|  | Monday | | | | Tuesday | | Wednesday | Thursday | Friday |
| am |  | | | |  | |  |  |  |
| pm |  | | | |  | |  |  |  |

**5. SUPERVISOR(S)**

*It is mandatory that you have at least one supervisor for the period(s) of training indicated on this application form. Supervisors can submit composite Supervisor’s Reports, although if their feedback differs, separate reports should be submitted to the College.* ***Please note, both you and your supervisors must sign this application before it is submitted to the College.***

*Supervisors are encouraged to attend workshops run by the College to inform them about the educational use of the PREP Tools which underpin the Curriculum.  Information about these workshops can be found on the* [*AT Supervisors Support*](https://www.racp.edu.au/fellows/supervision) *page of the College website.*

*Trainees are required to show previous supervisors’ reports to current supervisors in order to assist both trainees and supervisors with the development of relevant learning plans for the current training period. This requirement is not applicable if this is the first advanced training period.*

**Supervisor 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name of Supervisor: |  | | |
| Qualification(s): |  | | |
| Phone: (W) |  | Fax: (W) |  |
| E-mail: |  | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please specify the period of supervision: | | | | Commencing |  | | | Ending: |  |
|  | dd/mm/yy | | | | dd/mm/yy |
|  | I (supervisor) have sighted the supervisors’ reports from previous training periods and other documentation relevant to the trainee’s progression (if applicable) for this trainee and identified any ongoing issues for inclusion in the trainee’s learning plan for this period. | | | | | | | | |
| Supervisor’s Signature: | |  | | | Date: |  | | | |

***Signature not required where trainee will be including the supervisor/s in the email submission to the college.***

**Supervisor 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name of Supervisor: |  | | |
| Qualification(s): |  | | |
| Full Address: |  | | |
| Phone: (W) |  | Fax: (W) |  |
| E-mail: |  | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please specify the period of supervision: | | | | Commencing |  | | | Ending: |  |
|  | dd/mm/yy | | | | dd/mm/yy |
|  | I (supervisor) have sighted the supervisors’ reports from previous training periods and other documentation relevant to the trainee’s progression (if applicable) for this trainee and identified any ongoing issues for inclusion in the trainee’s learning plan for this period. | | | | | | | | |
| Supervisor’s Signature: | |  | | | Date: |  | | | |

***Signature not required where trainee will be including the supervisor/s in the email submission to the college.***

**Mentor (New Zealand Trainees)**

Trainees are strongly recommended to nominate a mentor to provide guidance through their career development. A mentor can provide advice, coaching, encouragement, feedback and support and, if a problem arises, may be a useful advocate between you and your supervisors and the College. A mentor should not be a supervisor and need not be in the same area or hospital as long as regular contact is maintained.

Name of Mentor      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mentor’s contact details       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. CCH Educational Tutorial Series**

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| --- |
| It is a requirement for Community Child Health (CCH) Advanced Trainees to attend 12 months of CCH Educational Tutorial Series (Weekly attendance for Australian Advanced Trainees, fortnightly attendance for New Zealand Advanced Trainees). For more information please refer to the CCH Handbook and Curriculum found on the [CCH specialty webpage](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/community-child-health).  CCH Educational Tutorial series typically includes topics in the following domains:   * Developmental – behavioural paediatrics * Child protection * Child population health * Professional skills   Trainees should track their attendance via the Supervisor’s Report, or by submitting the Record of [Attendance at CCH Educational Tutorial Series form](https://www.racp.edu.au/docs/default-source/default-document-library/ela-at-community-child-health-educational-tutorial-series-attendance-record.docx?sfvrsn=56d7131a_0) at the end of each rotation where they attended the CCH Educational Tutorial Series. |

*Please provide the following details of planned attendance of CCH Educational Tutorial Series for this year:*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Setting: |  | | |
| Rotation Start date: |  | End date: |  |
| Number of months attendance: |  | | |

**7. PROJECT PLAN**

The Training Committee in Community Child Health requires advanced trainees to submit one project by the end of their final year of training. Please provide details of your project

|  |  |
| --- | --- |
| Title of project: |  |
|  |  |
| Project supervisor: |  |
|  |  |
| Timetable for completion of project and expected Submission date: |  |
| Brief outline of project |  |
|  |  |

**8. BRIEF OUTLINE OF ADVANCED TRAINING ALREADY UNDERTAKEN**

|  |
| --- |
|  |

**9. BRIEF OUTLINE OF ADVANCED TRAINING INTENDED SUBSEQUENT TO THIS YEAR**

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|  |

**10. RECIPROCAL TRAINING ARRANGMENTS – Paediatrics and Child and Adolescent Psychiatry** *(please tick boxes that apply)*

The Royal Australasian College of Physicians (RACP) and Royal Australian and New Zealand College of Psychiatrists (RANZCP) have developed reciprocal training arrangements which provide trainees and supervisors advice on how to complete Advanced Physician Training in Community Child Health concurrently with training in Child and Adolescent Psychiatry.

Please refer to the [2017 Paediatrics and Child and Adolescent Psychiatry Reciprocal Training Arrangements Guide](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/community-child-health) for further information prior to completing this section. You can also contact the RACP on [CommunityChildHealth@racp.edu.au](mailto:CommunityChildHealth@racp.edu.au) or the RANZCP on [training@ranzcp.org](mailto:training@ranzcp.org).

Trainees must indicate on the annual application that they wish to take part in the reciprocal training arrangements. Trainee details will be provided to the RANZCP who will then contact trainees about the selection process for RANZCP.

I wish to take part in the reciprocal training arrangements and permit the RACP to provide my contact details to the RANZCP

I do not wish to take part in the reciprocal training arrangements.

**11. TRAINEE DECLARATION** *(please tick boxes that apply)*

|  |  |
| --- | --- |
|  | I declare the information supplied on this form is complete and accurate |
|  | I have familiarised myself with my obligations as documented in the [Advanced Training Program Requirements Handbooks](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/palliative-medicine) and [Education Policies](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/cardiology). |
|  | I have provided my supervisor(s) with copies of supervisors’ reports from previous training periods and other documentation relevant to my progression |
|  | I have liaised with my supervisor to confirm that the position outlined within this application is in line with the current accreditation granted for this setting and/or, where accreditation of the setting is not required, meets the standards for training. |
|  | My supervisors have confirmed the training information included in this application and have signed this form. |

|  |  |  |  |
| --- | --- | --- | --- |
| Trainee’s Signature: |  | Date: |  |

**Please ensure you make a copy of the completed application form for your personal records.**