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| P62#y1 | **Committee for Joint College Training (CJCT) in Paediatric Emergency Medicine** |
| **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.](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:** Ensure you have read and familiarised yourself with the Paediatric Emergency Medicine Advanced Training Program handbook and](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/paediatric-emergency-medicine) [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policies)[.](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/paediatric-emergency-medicine)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 Special Consideration outlining](https://www.racp.edu.au/trainees/flexible-training-options/exceptional-circumstances) [the reasons for](https://www.racp.edu.au/trainees/flexible-training-options/exceptional-circumstances) 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.See the [current training fees schedule.](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 or call (+61) 2 9256 9629 or (+61) 2 9256 9621 to discuss the matter.Aotearoa NZ contact details: racp@racp.org.nz |
| **Enquiries and submission** |
| **Enquiries**Email: PaedEmergency@racp.edu.au Phone: +61 2 9256 5444**Submission**Please ensure you have saved a copy for your records and email an electronically saved or clearly scanned copy to PaedEmergency@racp.edu.au (photos will not be accepted). Please CC in your nominated supervisors for their records. |

**Committee for Joint College Training in Paediatric Emergency Medicine**

**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 |       |

Note: 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 PaedEmergency@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 [MyRACP.](https://my.racp.edu.au/)

|  |  |
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| [ ]  | Please tick the following box if you wish to be removed from the contact list provided to the Australasian College of Emergency Medicine (ACEM)  |

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Member Identification Number (MIN)

If you don’t know your MIN, leave it blank.

Are you of Aboriginal, Torres Strait or Māori origin? [ ]  No

For persons of both Aboriginal and Torres Strait Islander origin, [ ]  Yes, Aboriginal

mark both ‘yes’ boxes. [ ]  Yes, Torres Strait Islander

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[ ]  Yes, Māori

Māori iwi affiliation

**2. TRAINEE DETAILS**

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| **Region:**Where you completed Basic Training**Division: Training Status:** | [ ]  Australia [ ]  Adult Medicine[ ]  **Advanced Training**(completed Basic training and passed the RACP Examination) | [ ]  Aotearoa New Zealand[ ]  Paediatrics & Child Health[ ]  **Post-Fellowship 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 submit **one application** to the College only — 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 **Paediatric Emergency** Secondary committee

(most relevant to enclosed training rotations) **Medicine**  (other committee to be aware of rotation details)

**4. DETAILS OF TRAINING PROGRAM**

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Year of Advanced Training:

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|       |

Employing Health Service/Institution:

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Number of terms (or rotations) indicated

on this application:

TIP: One term should be allotted to a single rotation to a different site

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For trainees commencing PEM training have [ ]  No If yes, please specify supervisor’s name:
you discussed this application with your [ ]  Yes

local Director of Paediatric Emergency Medicine?

Note: For all Aotearoa New Zealand trainees, please contact the clinical director at Starship Hospital.

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**TERM No.**

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Training in the following subspecialty e.g. Paediatric emergency medicine, paediatric intensive care, adult emergency medicine

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| --- |
|       % |

[ ]  Full time or [ ]  Part time If part time, percentage of full-time training:

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|      dd/mm/yy |

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Duration of this training term (months) Commencing: Ending:

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Post or position:

Hospital/Institution:

Address:

Appointment in:

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Public hospital Private hospital Public facilities in Private outpatient Other
 clinics within public

**Please provide a weekly timetable of your position(s), outlining what you are doing each day or use the template provided below.**

Term to also count towards Development & Psychosocial Requirement: [ ]

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**TERM No.**

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Training in the following subspecialty e.g. Paediatric emergency medicine, paediatric intensive care, adult emergency medicine

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[ ]  Full time or [ ]  Part time If part time, percentage of full-time training:

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Duration of this training term (months) Commencing: Ending:

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Post or position:

Hospital/Institution:

Address:

Appointment in:

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Public hospital Private hospital Public facilities in Private outpatient Other
 clinics within public

**Please provide a weekly timetable of your position(s), outlining what you are doing each day or use the template provided below.**

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**Clinical activities and responsibilities**

Hours spent in clinical activities per week Hours expressed as percentage

 of total hours per week

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Specialty of clinics:

**Research**

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Hours spent in clinical activities per week Hours expressed as percentage

of total hours per week

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Research topic:

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**TERM No.**

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| am |       |       |       |       |       |
| pm |       |       |       |       |       |

**5. DETAILS OF TRAINING PROGRAM (cont.)
 If more than two rotations undertaken during the training year**

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**TERM No.**

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Training in the following subspecialty e.g. Paediatric emergency medicine, paediatric intensive care, adult emergency medicine

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[ ]  Full time or [ ]  Part time If part time, percentage of full-time training:

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Duration of this training term (months) Commencing: Ending:

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Post or position:

Hospital/Institution:

Address:

Appointment in:

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Public hospital Private hospital Public facilities in Private outpatient Other
 clinics within public

**Please provide a weekly timetable of your position(s), outlining what you are doing each day or use the template provided below.**

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**Clinical activities and responsibilities**

Hours spent in clinical activities per week Hours expressed as percentage

 of total hours per week

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Specialty of clinics:

**Research**

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Hours spent in clinical activities per week Hours expressed as percentage

of total hours per week

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Research topic:

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**TERM No.**

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|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
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| pm |       |       |       |       |       |

**6. SUPERVISORS**

It is mandatory that you have two supervisors for the period(s) of training indicated on this application form.

Both supervisors can submit composite Supervisor’s Report, although if their feedback differs, separate reports should be submitted to the College. Both you and your supervisors must sign this application before it is submitted to the College.

**Supervisor 1**

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Supervisor’s full name

Qualification(s)

Phone (W):

Email:

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|      dd/mm/yy |

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Please specify the period of supervision: Commencing: Ending:

[ ]  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.

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Supervisor’s signature: Date:

**Supervisor 2**

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Supervisor’s full name:

Qualification(s):

Phone (W):

Email:

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Please specify the period of supervision: Commencing: Ending:

[ ]  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.

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Supervisor’s signature: Date:

**7. OTHER TRAINING ACTIVITIES**

**Teaching**

Please give details of teaching available to you and indicate frequency.

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Grand Rounds:

Lectures:

Seminars ‘in-house’:

Courses of conferences
you plan to attend:

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Do you teach others:

If yes, please indicate hours per week spent in teaching:

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Undergraduates: Basic trainees: Nursing staff:

**PALS Course**

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Have you completed a PALS course? [ ]  No [ ]  Yes Year completed:

**8. PROJECT PLAN**

TheCJCT in Paediatric Emergency Medicine requires all trainees to submit a project plan and the name of a project supervisor to the College by the end of the 1st year of training. **Trainees entering their second year** should provide a brief outline of their proposed project and expected dates of submission on this form, or indicate that the project requirement has been completed previously. If you plan to meet this requirement through the completion of two approved university subjects, please attach documentary evidence of course enrolment and description.

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Title of Project:

Project Supervisor:

Timetable or completion of
project and expected
submission date:

Brief outline of project:

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

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

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**11. MENTOR DURING TRAINING IN ADULT EMERGENCY DEPARTMENTS**

The mentor (in addition to the supervisors) should be a paediatric emergency physician who should provide guidance and supervision during the adult emergency rotation.

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Supervisor’s full name:

Qualification(s):

Phone (W):

Email:

The Mentor has agreed to act as my mentor (subject to confirmation of my appointment) and is prepared to report to the College as required. (Both trainee and supervisor must sign the application before it is submitted to the College.)

**Which term will you be working with the trainee?**

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|      dd/mm/yy |

Commencing: Ending:

Mentor’s signature Date (dd/mm/yy) Trainee’s signature Date (dd/mm/yy)

**12. 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 [Paediatric Emergency Medicine](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/paediatric-emergency-medicine) [Advanced Training Progra](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/paediatric-emergency-medicine)m handbook and [Education Policies.](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy)

[ ]  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

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Trainee’s signature: Date:

**Please ensure you make a copy of the completed application form for your personal records and send the original to the College by the due date.**