 2020 Advanced Training

Rotation Amendment Form Adolescent and Young Adult Medicine

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| **Important information** |
| This form has been developed to manage changes to approved advanced training rotations due to the impact of the COVID-19 pandemic. Further information on the RACP response to the pandemic can be found on the [RACP website](https://www.racp.edu.au/news-and-events/covid-19).  Instructions:   1. Before you complete this form, please ensure you have read and familiarised yourself with the relevant [Advanced Training Program Requirements Handbook](http://www.racp.edu.au/trainees/advanced-training). 2. Submit this form with your mid-year or end of year Supervisor’s Report for the relevant rotation. 3. This form must be signed by the supervisor(s) of the amended rotation. |

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| **Privacy legislation** |
| The RACP complies with the requirements of the national Privacy Act 1988 (Cwlth) (Australia) and the Privacy Act 1993 (New Zealand) and has adopted the Australian National Privacy Principles as the guidelines for ensuring the protection of personal information in its care. This policy applies to all personal information collected, stored, used and disclosed by the College. Further details can be found on the RACP [website](https://www.racp.edu.au/docs/default-source/default-document-library/pol-privacy-personal-information.pdf?sfvrsn=2). |

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| **Trainee personal details** |
| |  |  |  | | --- | --- | --- | | Surname: |  | | | First/given name: |  | | |  | | | |  | | | | Member Identification Number (MIN): |  |  | | Primary Specialty Training Program: |  | | | Secondary Specialty Training Program(s): |  | | |

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| **Details of approved rotation to be amended** |
| Please complete a separate form for each rotation to be amended. |
| |  |  | | --- | --- | | Rotation name/type: |  | | Training setting: |  | | Start date: |  | | End date: |  | |

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| **Details of change to approved rotation** | | | | | |
| Has your rotation changed as a result of COVID-19? Y / N  *E.g. reduction in access to clinics due to the impact of COVID-19 or deployed to a COVID-19 team.* | | | | | |
| Dates of change of rotation/run: | | | | | |
| Did the deployment/change result in a move to a different training setting? Y / N  If yes, name of setting: | | | | | |
| Did the deployment/change result in a change to your approved supervisor(s)? Y / N  If yes, name of original supervisor(s):  Name of new supervisor(s): | | | | | |
| Please provide a brief outline of duties undertaken during this period. Include the main clinical responsibilities, patient mix, administrative responsibilities etc. (attach a separate page if required): | | | | | |
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| Has Covid-19 impacted the number of AYA patients you have seen during this training period?  If yes, please provide further information on the increase/decrease in patients. | | | | | |
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| Please provide details of your amended timetable: | | | | | |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **AM** |  |  |  |  |  |
| **PM** |  |  |  |  |  |

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| **Other circumstances**  Please outline any other circumstances that **as a result of COVID-19** have impacted your training (such as pregnancy, personal health, caregiver and family responsibilities, altered job roles): |
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| **Supervisor declaration**  Signatures are optional but if not signed, supervisors must be copied into the submission email.  This form cannot be accepted if the declaration box is not completed. |
| |  |  | | --- | --- | | I declare the information supplied on this form is complete and accurate | | | Supervisor name: |  | | Supervisor signature: |  | | Date: |  | |  | | | I declare the information supplied on this form is complete and accurate | | | Supervisor name: |  | | Supervisor signature: |  | | Date: |  | |

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| **Trainee declaration**  This form cannot be accepted if the declaration box is not completed. |
| |  |  | | --- | --- | | I have discussed this amendment with my supervisor/s and declare the information supplied on this form is complete and accurate. | | | Date: |  | |  | | |