



Australasian Faculty of  
Rehabilitation Medicine



The Royal Australasian  
College of Physicians

## APPLICATION FORM TO BECOME A TRAINEE

### 1. PROGRAM

I hereby apply to become a trainee of the Australasian Faculty of Rehabilitation Medicine specialising in:

- General Rehabilitation  
 Paediatric Rehabilitation

Signature of Trainee ..... Date .....

### 2. PERSONAL DETAILS

(PLEASE PRINT NEATLY)

SURNAME \_\_\_\_\_

GIVEN NAMES \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_ PREFERRED TITLE \_\_\_\_\_

RESIDENCY STATUS \_\_\_\_\_

DATE OF BIRTH        /        /        MALE  FEMALE

DO YOU IDENTIFY YOURSELF AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?        YES         NO

FOR TRAINEES IN NEW ZEALAND, WHICH ETHNIC GROUP DO YOU BELONG TO?        New Zealand European         Maori         Other

BUSINESS ADDRESS \_\_\_\_\_  
INSTITUTION \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ (W) \_\_\_\_\_ (H) \_\_\_\_\_ (Mob)

FAX \_\_\_\_\_ (W) \_\_\_\_\_ (H)

PREFERRED EMAIL ADDRESS \_\_\_\_\_

PREFERRED ADDRESS FOR FACULTY MAIL        Business         Home

### 3. UNDERGRADUATE DEGREE

MEDICAL SCHOOL \_\_\_\_\_

DATE OF GRADUATION        /        /        (dd/mm/yyyy)

DEGREE \_\_\_\_\_



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**4. POSTGRADUATE QUALIFICATIONS**

a) Intern Year \_\_\_\_\_ Country \_\_\_\_\_

b) Examination(s) Passed \_\_\_\_\_ IF NOT AUSTRALIA

FRACP Written  FRACP Clinical

c) Other Qualifications

Date	Award	Institution

**5. NAMES AND ADDRESSES OF TWO (2) REFEREES**

(Two of your referees should have been supervisors of your clinical work)

1. \_\_\_\_\_

2. \_\_\_\_\_

**6. PRESENT POSITION**

Dates of Appointment: Commencing  Ending

For  hours a week.

Position/Post \_\_\_\_\_

Hospital \_\_\_\_\_

Supervisor \_\_\_\_\_

Application Document Checklist	
Check Box	Please enclose the following documentation together with application form:
<input type="checkbox"/>	Certified ** copy of <b>current General Medical Registration</b> in Australia/New Zealand
<input type="checkbox"/>	Certified ** copies of qualifications
<input type="checkbox"/>	Detailed Curriculum Vitae (this should include hospital positions with dates in chronological order)
<input type="checkbox"/>	Documentary evidence of two years post graduate training (e.g. letter or certificate from Medical Superintendent in which all training positions including the dates of post graduate training are clearly identified)
<input type="checkbox"/>	Documentary evidence of appointment to an appropriate AFRM accredited training position
<b>** Documents must be individually noted by a JP: "I have sighted the original of this document and verify that this is a true copy".</b>	

**Applications should be submitted to:** Royal Australasian College of Physicians, Attn: AFRM Education Officer, 145 Macquarie Street, Sydney NSW 2000.