

**Short Term Training in a Medical Specialty**

Application Form

**Instructions:**

Use this form to apply for short term training in a medical specialty with The Royal Australasian College of Physicians (RACP).

In line with the Medical Board of Australia’s guidelines for short-term training[[1]](#footnote-2), this pathway is available to international medical graduates (IMGs) who are applying for limited registration for postgraduate training or supervised practice, and

1. are recognised as qualified specialists in another country of training (outside Australia), or
2. are specialists-in-training in another country (outside Australia) and who
3. are likely to be no more than two years away from completing their specialist training, **and**
4. have passed a basic specialist examination or have satisfactorily completed substantial training (generally three or more years, i.e. PGY 5).

Before submitting an application for short term training in a medical specialty you must:

* Acquaint yourself with the registration requirements in Australia and the documentation that may be requested. Please refer to the Medical Board of Australia[[2]](#footnote-3) for further details.
* Read the RACP’s Short Term Training in a Medical Specialty - Policy for Applicants[[3]](#footnote-4).
* Apply to the Australian Medical Council (AMC) for primary source verification[[4]](#footnote-5) of your qualifications.
* **Review the conditions associated with this pathway and determine if it is the right registration pathway for you. The Medical Board stipulate that short-term training is for a period of up to 24 months. If you intend to practice in Australia for longer than 24 months, you are encouraged to explore other registration pathways. Please contact AHPRA[[5]](#footnote-6) for further information on this.**

The RACP has a specific role under the Medical Board of Australia (MBA) to assess whether: the IMG is a genuine specialist in training or internationally qualified specialist; whether the position is appropriate for the IMGs level of training and experience; and whether there is adequate supervision and support for the IMGs level of training and experience. This recommendation is provided to the MBA for the purposes of limited registration only.

Please ensure you have all documents required to submit a complete application and that all documents are typed, signed correctly and submitted electronically to IMG@racp.edu.au. Additional documents that are not required for an application with the RACP will be deleted. There will be significant delays to the application process if you do not submit all the required documentation (please refer to the checklist on page 2). The RACP will only accept complete applications and will not progress any application until documentation is submitted in the format required.

Upon receipt of your application, the RACP will request that you pay the short-term specialist training application fee[[6]](#footnote-7) online. You will receive a link from the RACP in order to pay this fee. Your application will not progress until this fee is paid.

For all additional questions please contact the OTP Unit at IMG@racp.edu.au.

**Checklist of documents required for short term training in a medical speciality application:**

|  |
| --- |
| The following items are mandatory. Your application will not be progressed until all of the below documents are received by the RACP.  |
| Included in this application form:[ ]  ***Curriculum vitae (RACP template only):***see page 3.[ ]  ***Training Program (RACP template only)\*:***see page 9. The training program must provide detailed information in each section of the attached template and should be completed and signed by you and your supervisors. You may want to consult the advanced training section of the RACP website to assist with identifying the objectives and work based assessments for the relevant specialty. The information provided should be specific to your period of training in Australia. Generic training programs will not be accepted. [ ]  ***Declaration by the Employer (RACP template only):*** see page 12. This form must be signed by one of the nominated supervisors outlined in the training program or the employer/sponsor nominated within the AAMC-30 form.[ ] ***Statement of Intention (RACP template only):*** see page 13. If you intend to remain in Australia for longer than 24 months, this may not be the right registration pathway for you. Please consult AHPRA in this case. Documentation required to be submitted by you: [ ]  ***Primary source verification of qualifications via the Australian Medical Council (AMC):***the Medical Board of Australia requires you to apply to the Australian Medical Council (AMC) for primary source verification (PSV) of your primary medical degree and specialist qualification (if obtained). Your qualifications must be submitted via the AMC and show a verification status of ‘outsourced’ or ‘verified’ before the College can proceed with your application. If you have already submitted your qualifications for primary source verification via the AMC, please ensure you have allowed the RACP to have access to your AMC portfolio.[ ]  ***Payment of the short term specialist training application fee online:*** you will receive a link from the RACP upon submission of your application.[ ]  ***AAMC-30 form:***this can be downloaded from the [MBA website](https://www.medicalboard.gov.au/registration/forms.aspx).[ ]  ***Position description:***this must be submitted on hospital letterhead and should state the same position title, location and the start and end dates as the training program. Under the Medical Board guidelines, RACP cannot approve service positions for short-term training. Position descriptions that clearly stipulate the role is for service provision only will result in the application being declined.[ ]  ***Trainee Statement:***This letter should outline your training objectives and the reasons/benefits for undertaking this training in Australia. The College does not provide a template for this statement as it should be based on your own individual training needs.If you have not yet obtained an overseas specialist qualification: [ ]  ***College or State Medical Council Letter:***This letter will need to be submitted on College or State Medical Council letterhead and confirm that you are currently enrolled in a specialist training program and are within two years of completion of training (i.e. PGY5)). The objectives of the training to be undertaken in Australia must be outlined in this letter. |



**”INSERT NAME”**

**CURRICULUM VITAE**

**PERSONAL DETAILS:**

|  |  |
| --- | --- |
| Family name (surname): |       |
| Given names: |       |
| Date of birth: | DD/MM/YYYY |
| Gender: | Male [ ]  / Female [ ]  / Self-described [ ] (please specify): ­      ­­­ Prefer not to say [ ]  |
| Preferred contact address for correspondence: |       |
| Phone: | (h)       | (m)       |
| (w)       |  |
| Contact email address: |       |
| Work email address (if different): |       |

**PRIMARY SOURCE VERIFICATION:**

|  |
| --- |
| All specialist assessment applicants require primary source verification of their medical qualifications through the International Credentials Services of the Educational Commission for Foreign Medical Graduates (ECFMG).Applicants must apply to the AMC (<http://www.amc.org.au/index.php/ass/psv>) for EPIC verification. The documents will be forwarded to the ECFMG for verification through the original issuing university or institution. When confirmation of verification is received by the AMC, the candidate will be informed.  |
| EPIC number: |       |
| AMC number: |       |
| If primary source verification has not yet been verified, please tick to confirm that application has been submitted: Yes [ ] Date: DD/MM/YYYY |

QUALIFICATIONS:

DEGREES OBTAINED BEFORE (PRIMARY) MEDICAL DEGREE (IF ANY):

|  |  |
| --- | --- |
| Qualification title: |       |
| Year qualified: |       |
| Year awarded (if different to year qualified for degree): |       |
| Country of training: |       |
| Controlling university: |       |

PRIMARY MEDICAL QUALIFICATION (MBBS OR EQUIVALENT):

|  |  |
| --- | --- |
| Qualification title: |       |
| Year qualified: | YYYY |
| Year awarded (if different to year qualified for degree): | YYYY |
| Country of training: |       |
| Medical school: |       |
| Controlling university: |       |
| Duration of training – years: (please select): | 2[ ]  3 [ ]  4[ ]  5 [ ]  >5 [ ]  (specify)       |
| Was a period of internship included in qualification? Yes [ ]  / No [ ] If yes, what dates? From: MM/YYYY To: MM/YYYY |

SPECIALIST QUALIFICATION (PRINCIPAL/HIGHEST):

If you are currently completing your specialist training, please enter the specialist qualification that you will be awarded at the end of your training.

|  |  |
| --- | --- |
| Qualification title: |       |
| Year qualified: | YYYY |
| Year awarded (if different to year qualified for degree): | YYYY |
| Country of training: |       |
| Institution awarding qualification: |       |
| Duration of training – years: (please select): |  2[ ]  3 [ ]  4[ ]  5 [ ]  >5 [ ]  (specify)       |
| Number of years to completion of specialist training – years (please select): | 1[ ]  2[ ]  3 [ ]   |

HIGHER DEGREES OBTAINED DURING OR AFTER OBTAINING SPECIALIST QUALIFICATION:

|  |  |
| --- | --- |
| Qualification title or title of thesis: |       |
| Year awarded: | YYYY |
| Country of training: |       |
| Institution awarding qualification: |       |
| Duration of training – years: (please select): |  2[ ]  3 [ ]  4[ ]  5 [ ]  >5 [ ]  (specify)       |

MEMBERSHIPS OF PROFESSIONAL ORGANISATIONS:

|  |
| --- |
| Please include memberships of all relevant organisations |
| Date from/to: | Organisation: |
| DD/MM/YYYY - DD/MM/YYYY |       |
| DD/MM/YYYY - DD/MM/YYYY |       |
| DD/MM/YYYY - DD/MM/YYYY |       |

TRAINING: CERTIFICATES AND COURSES:

|  |
| --- |
| *Please list all relevant courses attended and certificates gained*  |
| *Date:* | *Course/ certificate:* |
| MM/YYYY |  |
| MM/YYYY |  |
| MM/YYYY |  |

EXAMINATIONS AND ASSESSMENTS (PLEASE INCLUDE DETAILS OF ALL EXAMINATIONS AND ASSESSMENTS COMPLETED DURING TRAINING):

|  |  |
| --- | --- |
| Date of completion: | DD/MM/YYYY |
| Examining/assessment body: |       |
| Specialty/ sub-specialty:  |       |
| Components of examination/assessment(e.g. Multiple choice, essays): |       |
| Duration (hours): |       |
| Stage of training which examination/assessment was undertaken: |       |

CLINICAL/PROCEDURAL SKILLS:

|  |  |
| --- | --- |
| Competent | Observed |
|       |       |
|       |       |
|       |       |

DETAILED EMPLOYMENT HISTORY:

|  |
| --- |
| Please list all employment in chronological order starting with your current/most recent position; include those positions held during your medical training (including your internship) and any other employment before specialist training. Please ensure that you list the dates you commenced and ceased employment in each position (in month and year format MM/YYYY). Provide an explanation for any gaps that appear in your employment history. Provide full locations of all positions and brief description of day to day duties.Clearly identify your intern year (postgraduate year 1) and other years between obtaining your medical degree and commencing specialist training.Employment history should be completed in three sections to indicate employment in specialist practice (after award of principal specialist qualification), employment during specialist training and employment before specialist training.Copy table as required. |
| EMPLOYMENT IN SPECIALIST PRACTICE (AFTER AWARD OF PRINCIPAL SPECIALIST QUQUALIFICATION): |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties: |       |
|  |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties: |       |

|  |  |
| --- | --- |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties: |       |

EMPLOYMENT DURING SPECIALIST TRAINING:

|  |  |
| --- | --- |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties & rotations completed: |       |

|  |  |
| --- | --- |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties & rotations completed: |       |

|  |  |
| --- | --- |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties & rotations completed: |       |

|  |
| --- |
| EMEMPLOYMENT BEFORE SPECIALIST TRAINING: |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties & rotations completed: |       |

|  |  |
| --- | --- |
| Start/end dates: | MM/YYYY |
| Institution/hospital: |       |
| Position title: |       |
| Location (include country): |       |
| Registering authority: |       |
| Duties & rotations completed: |       |

EXPERIENCE IN TEACHING, RESEARCH AND PROFESSIONAL ACTIVITIES:

TEACHING EXPERIENCE:

|  |
| --- |
| Please list all experience you have gained in delivering medical education (including the dates and institutions). Include formal appointments of academic institutions: |
| Dates: | MM/YYYY – MM/YYYY |
| Institution: |       |
| Position: |       |
| Nature of Practice: |       |

AUDIT PARTICIPATION, REPORTS, AND, RESEARCH EXPERIENCE:

|  |
| --- |
| Please provide a summary: |
|       |       |
|       |       |
|       |       |

PUBLISHED RESEARCH PAPERS:

|  |
| --- |
| Please provide full reference and link where possible (hard copies are not required): |
|       |       |
|       |       |
|       |       |

RESTRICTIONS ON PRACTICE:

|  |  |
| --- | --- |
| Are there any restrictions on your current practice? | [ ] Yes – Please comment below[ ] No |
| Have you ever been subject to an investigation of your practice or actions by a clinical practice regulatory authority? | [ ] Yes – Please comment below[ ] No |
|       |

DECLARATION BY APPLICANT:

|  |
| --- |
| I (print full name)      , do solemnly and sincerely declare that the statements made and the information shown in this application form and in the identified documents attached are true and complete. I wish to apply for short term training in a medical specialty by the Royal Australasian College of Physicians. I have familiarised myself with the requirements of this training pathway as set out by the College (<https://www.racp.edu.au/docs/default-source/default-document-library/specialist-assessment-guide-for-applicants-2015v1.pdf?sfvrsn=0> ) and also the requirements for registration in Australia with the Australian Health Practitioner Regulation Agency (<http://www.ahpra.gov.au/>). Furthermore, I acknowledge that the College may contact regulatory authorities (such as the Australian Medical Council and the Australian Health Practitioners Regulation Agency) in relation to my application. |
| Signature: |       |
| Date: | DD/MM/YYYY |



**TRAINING PROGRAM**

The DEPARTMENT at HOSPITAL has offered Dr NAME a POSITION in SPECIALTY for the DURATION period from START DATE to END DATE.

DETAIL ABOUT THE DEPARTMENT AND HOSPITAL: type of cases received, procedures undertaken, facilities and equipment available, staff numbers, etc.

Dr NAME’s goals and objectives for the DURATION will be:

Please type here.

To assist in meeting with these goals and objectives, Dr NAME will be expected to participate in the following activities within the department:

Supervisors must provide information on the supervision and the support that will be available for applicants for the clinical, teaching and research activities that will be undertaken during this period.

**Clinical activities:** Please provide a summary of these activities and the level of supervision and support available to the applicant.

**Teaching activities:** Please provide a summary of these activities and the level of supervision and support available to the applicant.

**Research activities:** Please provide a summary of these activities and the level of supervision and support available to the applicant.

If the applicant will be completing examination and assessments during their training, please list the anticipated date of these examinations and/or assessments.

Describe how these learning outcomes will be measured during the period of training.

STATEMENT: I confirm that aspects of the training that Dr NAME will be receiving at the HOSPITAL are not available in their country of practice.

Please list significant points of difference.

**DETAILED WEEKLY TIMETABLE**

(Please list all clinical activities, teaching activities, research activities and educational activities.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
| AM |       |       |       |       |       |
| PM |       |       |       |       |       |

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**SUPERVISION OF IMGs**

In addition to RACP requirements, you should be aware of the revised Medical Board of Australia (MBA) *Guidelines - Supervised practice for international medical graduates.* The guidelines take effect from 4 January 2016 and are published on the MBA website with information on the changes and transitional arrangements. [www.medicalboard.gov.au/Registration/International-Medical-Graduates/Supervision.aspx](http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Supervision.aspx)’

**Principal Supervisor**

|  |  |  |
| --- | --- | --- |
| Name of Supervisor: |       |       |
|  | First Name | Surname |
| Phone Number: |       |
|  |
| Email: |       |
|  |
| Do you hold specialist registration? | [ ]  Yes [ ] No |
|  |
| Have you had specialist registration for at least 3 years? | [ ]  Yes [ ]  No |
|  |
| Do you hold specialist registration in the same specialty as the position proposed by the applicant? | [ ]  Yes [ ]  No |
|  |
| Will you be an onsite supervisor? | [ ]  Yes [ ]  No |
|  |
| If yes, what site(s) will you be available as an onsite supervisor? |       |
|  |  |
| What level of supervision is being requested from Ahpra for this IMG? |       |
|  |  |
| What is your supervision arrangement and/or scheduled with the applicant? |       |
|  |  |
| How many IMGs are you currently supervising? |       |
| Which period will you be working with the applicant? |  |
|  |  |
| Commencing: |       | Ending: |       |

I have agreed to act as a supervisor for Dr NAME for the duration of their training program, during which time they will work in a X FTE POSITION in SPECIALTY.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |  |
| Signature of SupervisorDate |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |  |
| Signature of IMG Date |  |

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**Co-supervisor**

|  |  |  |
| --- | --- | --- |
| Name of Supervisor: |       |       |
|  | First Name | Surname |
| Phone Number: |       |
|  |
| Email: |       |
|  |
| Do you hold specialist registration? | [ ]  Yes [ ]  No |
|  |
| Have you had specialist registration for at least 12 months? | [ ]  Yes [ ]  No |
|  |
| Do you hold specialist registration in the same specialty as the position proposed by the applicant? | [ ]  Yes [ ]  No |
|  |
| Will you be an onsite supervisor? | [ ]  Yes [ ]  No |
|  |
| If yes, what site(s) will you be available as an onsite supervisor? |       |
|  |  |
| What level of supervision is being requested from Ahpra for this IMG? |       |
|  |  |
| What is your supervision arrangement and/or scheduled with the applicant? |       |
|  |  |
| How many IMGs are you currently supervising? |       |
| Which period will you be working with the applicant? |  |
| Commencing: |       | Ending: |       |

I have agreed to act as a co-supervisor for Dr NAME for the duration of their training program, during which time they will work in as a POSITION in SPECIALTY.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |  |
| Signature of SupervisorDate |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |  |
| Signature of IMG Date |  |

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**DECLARATION BY THE EMPLOYER**

The DEPARTMENT at HOSPITAL confirms that:

[ ]  This training position offered to Dr NAME as a POSITION in SPECIALTY constitutes a genuine training position which, complying with the [MBA Guidelines](file:///C%3A//Users/anhieu/Downloads/Guidelines---Short-term-training-in-a-medical-speciality-for-IMGs-not-qualified-for-general-or-specialist-registration---1-July-2016%20%289%29.PDF), means that is a training position accredited by RACP or is a formal structured training position that consists of formal assessment processes and mechanisms for measuring learning outcomes.

[ ]  The training position does not disadvantage any trainee in the RACP training program.

[ ]  The training position is not primarily a service position.

[ ]  The IMG intends to remain in Australia for a short period of training (no more than 24 months) only

Name of authorized officer: ........................................

Signature of authorized officer: ........................................

Date: ........................................

**STATEMENT OF INTENTION**

**Overseas Specialist OR Overseas Specialist in training**

I, Dr ...................................................................................................... confirm that:

* It is my intention to leave Australia at the completion of the attached training position/program, which shall not be for a period of longer than two years (24 months).
* I have read and understand the [*IMGs: Requirements for Undertaking Physician Training in Australia Policy*](https://www.racp.edu.au/docs/default-source/default-document-library/short-term-training-in-a-medical-specialty-guidelines-for-applicants.pdf?sfvrsn=7e92091a_4)which outlines the criteria which short term training in a medical specialty is approved.
* I have read and understand the [*Guidelines: Supervised Practice for International Medical Graduates*](https://www.medicalboard.gov.au/codes-guidelines-policies.aspx) which outlines the requirements for my supervision during this training.
* I do **not** intend to submit any further applications for registration at the end of the approved maximum period of training on this pathway.

Signature: ......................................................................................................

Date: ......................................................................................................

1. https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Short-term-training-guidelines.aspx [↑](#footnote-ref-2)
2. www.medicalboard.gov.au [↑](#footnote-ref-3)
3. https://www.racp.edu.au/overseas-specialists/short-term-specialist-training [↑](#footnote-ref-4)
4. www.amc.org.au/assessment/psv [↑](#footnote-ref-5)
5. https://www.ahpra.gov.au/ [↑](#footnote-ref-6)
6. www.racp.edu.au/become-a-physician/membership-fees [↑](#footnote-ref-7)