|  |  |  |
| --- | --- | --- |
|  | **Advanced Training Committee**  **in Clinical Pharmacology** | |
| **Application for Prospective Approval of Advanced Training** | | |
| **Important Information** | | |
| **PREP program**  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](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/clinical-pharmacology) Handbooks and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy).  Applications are required per training year and cannot exceed 12 months per application. | | |
| **Closing Dates** | | |
| **Australia** | | **Aotearoa New Zealand** |
| **28 February** for approval of the first half or the entire training year  **31 August** for approval of the second half of the training year | | **15 December** – first half or whole of the following year  **30 April** – May to August rotations  **30 June** – second half of the current 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 may attract a late fee. Consideration of applications submitted after the deadline may be delayed. Late applications will be considered up to 1 month after the deadline. Applications received 1 month after the deadline won’t be considered unless exceptional circumstances can be demonstrated. | | |
| **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 the Member Support Centre on 1300 697 227 (+61 2 9256 5444) or by completing the [query form](https://www.racp.edu.au/contact-us).  Aotearoa New Zealand contact details – 0508 697 227 (+64 4 472 6713) [racp@racp.org.nz](mailto:racp@racp.org.nz) | | |

|  |
| --- |
| **Pre-Submission Application Checklist** |
| |  |  | | --- | --- | | **✓ if completed** |  | |  | I have read and understood the important information on the front of this form. (Please check the [Advanced Training Program Requirements Handbook](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/clinical-pharmacology) if uncertain. Contact [ClinicalPharmacology@racp.edu.au](mailto:clinicalpharmacology@racp.edu.au) if still uncertain) | |  | My supervisors and I have signed this form in sections 5 and 9. | |  | I have completed all relevant areas in the application form. | |  | I have kept a copy of the completed application form for my personal records. | |  | I will send the completed application form to the College by the appropriate due date (see front of form). | | **Incomplete applications will be returned to the trainee.** | | |

|  |
| --- |
| **Enquiries & Submission** |
| **Enquiries** Email: [ClinicalPharmacology@racp.edu.au](mailto:ClinicalPharmacology@racp.edu.au)  Phone: 1300 697 227 (+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 [ClinicalPharmacology@racp.edu.au](mailto:ClinicalPharmacology@racp.edu.au) (photos will not be accepted). Please CC in your nominated supervisors for their records. |

**Advanced Training Committee in Clinical Pharmacology**

**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 [clinicalpharmacology@racp.edu.au](mailto:clinicalpharmacology@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 Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT) | | | | | |
|  |  | | | | | |
| 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:**  Where you completed Basic Training |  | Australia |  | New Zealand |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Training Status:** |  | **Advanced Training**  (completed Basic training and passed the FRACP Examination) |  | **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 multiple 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 multiple advanced training committees.*

|  |  |  |  |
| --- | --- | --- | --- |
| Primary committee  (most relevant to enclosed training rotations) | **Clinical Pharmacology** | Secondary committee  (other committee/s 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: One term should be allotted to a single rotation to a different site* | | | | | |
| Term/s to also count towards Developmental & Psychosocial? | | |  | | If yes, please specify dates |
|  | | |  | |  |
|  | | | | | |
| Is this term/s in a rural setting? | | |  | | If yes, please specify dates |
|  | | |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TERM No.** | | |  | |
|  | | | | | | | | | | | | | | | | |
| Training in the following subspecialty e.g.  Core Clinical, non-core clinical or research? etc. | | | | | | | | |  | | | | | | |
|  | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | Full time | or |  | | Part time | | | | | If part time, percentage of full time training: | | | % | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Duration of this training term (months): | | | | | | |  | | Commencing: | |  | Ending: |  |
| dd/mm/yy | | dd/mm/yy |
|  | |  |
| Post or position: | | | | | | |  | | | | | | | |
| Hospital/Institution: | | | | | | |  | | | | | | | |
| Address: | | | | | | |  | | | | | | | |
| Appointment in:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Please provide a weekly timetable for your position(s), outlining what you are doing each day or use the template provided in section 5.** | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TERM No.** | | |  | | |
|  | | | | | | | | | | | | | | | |
| Training in the following subspecialty e.g. Core Clinical, non-core clinical or research etc. | | | | | | | |  | | | | | | |
|  | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | Full time | or |  | Part time | | | | | If part time, percentage of full time training: | | | % | |
|  | | | | | | | | | | | | | | |
| Duration of this training term (months): | | | | | |  | | Commencing: | |  | Ending: |  |
| dd/mm/yy | | dd/mm/yy |
|  | |  |
|  | |  |
| Post or position: | | | | | |  | | | | | | | |
| Hospital/Institution: | | | | | |  | | | | | | | |
| Address: | | | | | |  | | | | | | | |
| Appointment in:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | |

**Please provide a weekly timetable for your position(s), outlining what you are doing each day or use the template provided in section 5.**

**5. WEEKLY TIMETABLES**

|  |  |  |
| --- | --- | --- |
| **TERM/S** | |  |
|  | Monday | | | Tuesday | Wednesday | Thursday | Friday |
| am |  | | |  |  |  |  |
| pm |  | | |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **TERM/S** | |  | |
|  | Monday | | Tuesday | | Wednesday | Thursday | Friday |
| am |  | |  | |  |  |  |
| pm |  | |  | |  |  |  |

**6. SUPERVISORS**

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

*You’re required to nominate*[*eligible supervisors*](https://www.racp.edu.au/fellows/supervision/supervisor-professional-development-program)*who meet the supervision requirements of the training program.* *You can find a list of eligible supervisors on*[*MyRACP*](https://my.racp.edu.au/)*.* *This list isn’t available for post-Fellowship trainees. Post-Fellowship trainees can contact us to confirm supervisor eligibility.*

*Both 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.***

**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: |  |

**Supervisor 2**

|  |  |  |  |
| --- | --- | --- | --- |
| 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: |  |

**Mentor (New Zealand trainees only)**

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 address

**7. TRAINING ACTIVITIES**

**Appointment In:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | % | |  | % | |  | % | |  | % |
| Public  Hospital | | | Private  Hospital | | | Private Facilities  In Public Hospital | | | Private Out-Patient Clinics Within Public Hospital | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | % | (please indicate): |  | |
| Other | | | |

**Clinical Activities and Responsibilities**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of inpatients | |  | Number of outpatient clinics |  | Number of ward rounds per week |  |
|  | | | | | | |
| Specialty of clinic(s) |  | | | | | |

|  |  |
| --- | --- |
| **Outpatient clinics to be attended (name) including:** | **Frequency (week/month/year)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Responsibilities at associated centres/peripheral hospitals (if applicable):

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hours in clinical activities per week |  | Hours expressed as a percentage of total hours per week | % | Frequency of grand rounds per week |  |

Details of seminar activities available ‘in house’:

|  |
| --- |
|  |

Details of conferences you plan to attend/have attended:

|  |
| --- |
|  |

**Teaching**

Indicate hours per week to be spent in teaching

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Undergraduates |  | Basic trainees |  | Nursing staff |  |

**Research**

|  |  |
| --- | --- |
| Indicate hours per week to be dedicated to research |  |

Details of research activities:

(A separate detailed report should be attached if the time spent in research is significant)

Give details of any papers you will be presenting/have presented during this period:

|  |
| --- |
|  |

Please append list of all publications under the headings original articles (including in press), conference papers, abstracts, chapters, lay press:

|  |
| --- |
|  |

**Project Topic**

Please describe the project report that you plan to undertake in consultation with your supervisor. Please refer to the handbook for information and guidance concerning preparation and submission of research projects.

|  |
| --- |
|  |

**8. COMPONENTS OF TRAINING IN CLINICAL PHARMACOLOGY**

**Please indicate what training you will receive in the following components of training and the number of hours you will spend on each.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Principles of basic pharmacology, of essential drug groups and** | Hours/week |  |  | |
| **mechanisms of action** | | | |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Principles of pharmacokinetics and pharmacodynamics** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Individual and population variance in drug response** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Therapeutic drug monitoring and reporting of plasma drug concentrations** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment of adverse drug reactions** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug committee activities** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug utilisation evaluation** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Evaluation of efficacy and safety data of new drugs, drug regulation** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Design and conduct of clinical trials** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug information (literature and computer sources)** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Basic research principles** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Quality use of medicine** | Hours/week |  |  |

Description of training

|  |
| --- |
|  |

**Non-Core Training**

Please indicate any other training relevant to clinical pharmacology that will be undertaken and the time that will be devoted to it. (eg research and development, toxicology, pharmacoepidemiology)

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

**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/clinical-pharmacology) 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. |

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

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