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| --- | --- |
| RACP2016_OL | Application for Prospective Approval of Advanced Training |
| **Advanced Training Committee in Geriatric Medicine and**  **New Zealand Advanced Training Subcommittee in Geriatric Medicine** | |
| **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 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 Handbooks](https://www.racp.edu.au/trainees/advanced-training) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy).  Applications can span multiple training years but may not exceed 12 months per application. | |
| **Closing Dates** | |
| |  |  | | --- | --- | | **Australia** | **New Zealand** | | **15 February** for approval of the first half of training year or the entire training year **31 August** for approval of the second half of the training year | **30 April** for approval of May-August rotations  **30 June** for approval of the second half of the year  **15 December** for approval of the first half or whole of the following 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 Consideration of Exceptional Circumstances](https://www.racp.edu.au/trainees/flexible-training-options/exceptional-circumstances) outlining the reasons for 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.  A schedule of current training fees is available here.  For queries or support regarding your training fees, please contact a Finance Officer by email [Accounts.Receivable@racp.edu.au](mailto:Accounts.Receivable@racp.edu.au) or call (+61) 2 9256 9629 or (+61) 2 9256 9621 to discuss the matter.  NZ contact details – [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/docs/default-source/default-document-library/at-geriatric-medicine-handbook-2017-18.pdf?sfvrsn=8) if uncertain. Contact [geriatrics@racp.edu.au](mailto:geriatrics@racp.edu.au) or [geriatrics@racp.org.nz](mailto:geriatrics@racp.org.nz) 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**  |  |  | | --- | --- | | **Australian Office** | **New Zealand Office** | | Email: [Geriatrics@racp.edu.au](mailto:Geriatrics@racp.edu.au)  Phone: +61 2 8247 6214 | Email: [Geriatrics@racp.org.nz](mailto:Geriatrics@racp.org.nz)  Phone: +64 4 472 6713 |  **Submission**Please ensure you have saved a copy for your records and email an electronically saved or clearly scanned copy to the email below (photos will not be accepted). Please CC in your nominated supervisors for their records.  |  |  | | --- | --- | | **Australian Office** | **New Zealand Office** | | Email: [Geriatrics@racp.edu.au](mailto:Geriatrics@racp.edu.au)  Phone: +61 2 8247 6214  **OR**  Education, Learning and Assessment  The Royal Australasian College of Physicians  145 Macquarie Street  SYDNEY NSW 2000 AUSTRALIA | Email: [Geriatrics@racp.org.nz](mailto:Geriatrics@racp.org.nz)  Phone: +64 4 472 6713  **OR**  Advanced Training  The Royal Australasian College of Physicians  P.O. Box 10 601  WELLINGTON 6143 NEW ZEALAND | | |

 Application for Prospective Approval of Advanced Training

**Advanced Training Committee in Geriatric Medicine and**

**New Zealand Advanced Training Subcommittee in Geriatric Medicine**

**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 [geriatrics@racp.edu.au](mailto:geriatrics@racp.edu.au) or [geriatrics@racp.org.nz](mailto:geriatrics@racp.org.nz) 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 Australian and New Zealand Society for Geriatric Medicine (ANZSGM). | | | | | |
|  |  | | | | | |
| 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 both 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 two advanced training committees.*

|  |  |  |  |
| --- | --- | --- | --- |
| Primary committee  (most relevant to enclosed training rotations) | **Geriatric Medicine** | Secondary committee  (other committee to be made aware of rotation details) |  |

**4. DETAILS OF TRAINING PROGRAM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year of Advanced Training: |  | |  | | |
|  | | | | | |
| Employing Health Service/Institution: |  | | | |
|  | | | | | |
| Number of terms indicated on this application: | |  | |  | |

TIP: If you are in one position for the whole period of training indicated on this form, please provide further details under Term 1 only.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TERM No.** | | | 1 | |
| Training in the following subspecialty : (Please tick **one area** in which the majority of training will occur) | | | | | | | | | | | | | | | | |
| Acute Geriatric Medicine  Community (including ACAT)  Education and Training  General Medicine | | | | | | Geriatric Medicine  Geriatric Rehabilitation Medicine  Orthogeriatrics  Perioperative Medicine  Psychogeriatrics/ Delirium Unit | | | | | | Rehabilitation Medicine  Research  Specialty Clinics  Stroke Unit  Subacute (e.g. GEM) | | | Other (please describe below) | |
|  | |
|  | |
| |  |  |  |  | | --- | --- | --- | --- | | **Pre-PREP trainees**  Approval sought for: | Core clinical | Non-core clinical | Research | | **PREP trainees**  Approval sought for: | Level A: Core clinical | Level B: Core clinical  Level B: Non-core clinical | Level C: Non-core clinical or Research |   *PREP trainees please refer to the guidelines on levels of training, in the current* [*Advanced Training Program Requirements Handbooks*](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/geriatric-medicine)*.*  *If the rotation is split (e.g. 50% acute aged care, 50% rehabilitation), please select the option that best demonstrates diversity of training.* | | | | | | | | | | | | | | | | | | |
|  | | 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.

|  |  |  |
| --- | --- | --- |
| **TERM No.** | | 1 |
|  | | | | | | | |
|  | **Monday** | | | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **am** |  | | |  |  |  |  |
| **pm** |  | | |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TERM No.** | | | 2 | |
| Training in the following subspecialty : (Please tick **one area** in which the majority of training will occur) | | | | | | | | | | | | | | | | |
| Acute Geriatric Medicine  Community (including ACAT)  Education and Training  General Medicine | | | | | | Geriatric Medicine  Geriatric Rehabilitation Medicine  Orthogeriatrics  Perioperative Medicine  Psychogeriatrics/ Delirium Unit | | | | | | Rehabilitation Medicine  Research  Specialty Clinics  Stroke Unit  Subacute (e.g. GEM) | | | Other (please describe below) | |
|  | |
| |  |  |  |  | | --- | --- | --- | --- | | **Pre-PREP trainees**  Approval sought for: | Core clinical | Non-core clinical | Research | | **PREP trainees**  Approval sought for: | Level A: Core clinical | Level B: Core clinical  Level B: Non-core clinical | Level C: Non-core clinical or Research |   *PREP trainees please refer to the guidelines on levels of training, in the current* [*Advanced Training Program Requirements Handbooks*](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/geriatric-medicine)*.*  *If the rotation is split (e.g. 50% acute aged care, 50% rehabilitation), please select the option that best demonstrates diversity of training.* | | | | | | | | | | | | | | | | | | |
|  | | 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **TERM No.** | | 2 (if applicable) | |
|  | | | | | | | |
|  | **Monday** | | **Tuesday** | | **Wednesday** | **Thursday** | **Friday** |
| **am** |  | |  | |  |  |  |
| **pm** |  | |  | |  |  |  |

**5. SUPERVISOR(S)**

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

*Supervisors are encouraged to attend workshops run by the College to inform them about the educational use of the PREP Tools which underpin the Curriculum.  Information about these workshops can be found* [*here*](http://www.racp.edu.au/fellows/supervision/supervisor-workshops)*.*

**Supervisor 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name of Supervisor: |  | | |
| Qualification(s): |  | | |
| Full Address: |  | | |
| 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): |  | | |
| Full Address: |  | | |
| 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: |  |

*It is recommended that all trainees have a mentor during training who is a Geriatrician.*

Australian Trainees are not required to record their mentor.

New Zealand Trainees are recommended to record their mentor.

**Mentor**

|  |  |
| --- | --- |
| Name of Mentor: |  |

**6. TRAINING ACTIVITIES**

**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 |  |

**Other Training Activities**

Details of seminar activity 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:

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

**9. 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/geriatric-medicine) 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. | | | | |
|  | I acknowledge my responsibility to notify the College as soon as possible of any changes in clinical responsibilities or supervisor/s from that outlined in this application. | | | | |
| Trainee’s Signature: | | |  | Date: |  |

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