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| --- | --- | --- |
|  | **Advanced Training in Medical Oncology**  **Application for Approval of Training**  **PREP Program** | |
| **Important Information** | | |
| This application form is for use by Advanced Trainees and Fellows who intend to undertake post-FRACP training.  If you intend to interrupt your training, take longer leave or withdraw from training, further information can be found [here](https://www.racp.edu.au/trainees/flexible-training-options).  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 Handbook](https://www.racp.edu.au/trainees/advanced-training/medical-oncology) 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** | | **New Zealand** |
| **28 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 | | **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/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) | | |

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| --- |
| **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/medical-oncology) if uncertain. Contact [medicaloncology@racp.edu.au](mailto:medicaloncology@racp.edu.au) or [medicaloncology@racp.org.nz](mailto:medicaloncology@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). | |
| **Enquiries & Application Submission** |
| |  |  | | --- | --- | | **Australian Office** | **New Zealand Office** | | Email: [medicaloncology@racp.edu.au](mailto:medicaloncology@racp.edu.au)  Phone: 1300 697 227 (+61 2 9256 5444) | Email: [medicaloncology@racp.org.nz](mailto:medicaloncology@racp.org.nz)  Phone: 0508 697 227 (+64 4 472 6713) |   Please ensure that you have saved a copy for your records and email an electronically saved or clearly scanned copy to the email above (photos will not be accepted). Please cc in your nominated supervisors for their records. |



**Advanced Training in Medical Oncology**

**Application for Approval of 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) | | | |
| Address |  | | | | | |
| Phone (H) |  | | Phone (W) | |  | |
| Phone (M) |  | | Fax | |  | |
| E-mail Contact |  | | | | | |
|  | **NB:** The College will use email as the primary method to communicate with you throughout your Advanced Training. It is important that you take the following steps:   * keep a valid email address on file with the College at all times * check your email regularly * ensure that you can receive emails from [medicalonology@racp.edu.au](mailto:medicalonology@racp.edu.au) (Australia) or [medicaloncology@racp.org.nz](mailto:medicaloncology@racp.org.nz) (New Zealand) by adding this addresses to your address book and/or safe senders list | | | | | |
|  |  | | | | | |
| Member ID No (MIN) |  |  | | | |
|  | |  | |  | |
| *If you don’t know your MIN, leave it blank.* | | **Are you of Aboriginal or Torres Strait Islander origin?** | | No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, Māori  Māori iwi affiliation  *For persons of both Aboriginal and Torres Strait Islander origin, mark both ‘yes’ boxes*. | |

***Please notify the College if any of these details change during the training term/rotation***

**2. TRAINEE DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region:**  Country 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) | | |
| **Curriculum:** | |  | | **Pre-PREP** | |  | | **PREP**  You are a PREP trainee if you first enrolled in the Medical Oncology program from 2011 onwards or you have previously opted in to the PREP program. |

**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) | **Medical Oncology** | 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 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.** | | | |  | |
|  | | | | | | | | | | | | | | | | | |
| Training in the following subspecialty e.g., Medical Oncology, Haematology, Palliative Medicine, Radiation Oncology or other (please specify): | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | |  | | | | | | |
| Core clinical, non -core clinical or research: | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | 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 attach:**  your **weekly timetable** for your position(s), outlining what you are doing each day (identifying all clinics)  your **job description** for your position(s)   |  |  | | --- | --- | |  | I have attached my weekly timetable and my job description for my position. I understand it is my responsibility to submit these to the College with my application. I understand failure to do so may result in a delayed approval decision of the training period. | | | | | | | | | | | | | | | | |
| **TERM No.** | | |  | | | | |
|  | | | | | | | | | | | | | | | | | |
| Training in the following subspecialty e.g., Medical Oncology, Haematology, Palliative Medicine, Radiation Oncology or other (please specify): | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | |  | | | | | | |
| Core clinical, non- core clinical or research: | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | 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 attach:**

your **weekly timetable** for your position(s), outlining what you are doing each day (identifying all clinics)

your **job description** for your position(s)

|  |  |
| --- | --- |
|  | I have attached my weekly timetable and my job description for my position. I understand it is my responsibility to submit these to the College with my application. I understand failure to do so may result in a delayed approval decision of the training period. |

**5. SUPERVISOR(S)**

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

*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 on the* [*Advanced Training Supervision*](https://www.racp.edu.au/fellows/supervision/advanced-training-supervision) *page.*

**Supervisor 1**

|  |  |
| --- | --- |
| Full Name of Supervisor: |  |
| Qualification(s): |  |
| Full Address: |  |
| Phone: (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:  ***Australian trainees*** *- Signature not required where trainee will be including the supervisor/s in the email submission to the College.* | |  | | | | Date: |  | |
|  | | | |  |  | |

**Supervisor 2**

|  |  |
| --- | --- |
| Full Name of Supervisor: |  |
| Qualification(s): |  |
| Full Address: |  |
| Phone: (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:  ***Australian trainees*** *- Signature not required where trainee will be including the supervisor/s in the email submission to the College.* | |  | | | | Date: |  | |

**6. 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):

|  |
| --- |
|  |

On-call and weekend responsibilities:

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

**Teaching**

Please give details of teaching available to you and indicate frequency

Grand rounds:

|  |
| --- |
|  |

Lectures:

|  |
| --- |
|  |

Seminars:

|  |
| --- |
|  |

Course or conferences you plan to attend:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Do you teach others? |  |

If yes, please indicate hours per week spend in teaching

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

**Research**

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

|  |  |
| --- | --- |
| Hours expressed as a percentage of total hours per week | % |

Brief outline of research topic:

|  |
| --- |
|  |

***A separate detailed report should be attached if the time spent in research is significant.***

**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](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/medical-oncology) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy). | | | | |
|  | I have provided my supervisor(s) with copies of Supervisor’s 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. | | | | |
|  | 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 relevant due date.**