|  |  |
| --- | --- |
| RACP2016_OL | **Training Committee in Palliative Medicine** |
| **Application for** **Entry into Advanced Training in Palliative Medicine** | |
| **Important Information** | |
| This application is for use by doctors who are interested in joining the Chapter of Palliative Medicine training program.  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/advanced-training-programs/palliative-medicine) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy). | |
| **Closing Dates** | |
| **15 February** if commencing training in the first half of the year  **31 August** if commencing training in the second half of the year | |
| **Applications for Approval of Training** | |
| Upon submission of this application you will be assessed for eligibility to enter the program.  Successful applicants should also complete an Application for Approval of Advanced Training (found [here](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/palliative-medicine)) with their supervisor for prospective approval of their training. | |
| **Privacy** | |
| The Royal Australasian College of Physicians is committed to protecting your personal information. We collect your personal information so that we can, amongst other things, conduct training, peer review, and examinations. Please refer to the [Privacy Collection Statement](https://www.racp.edu.au/home/privacy/collection-statement) and the [Privacy Policy](https://www.racp.edu.au/home/privacy/policy) on the RACP website.  The College complies with the requirements of the national Privacy Act 1988 (Cwlth) (Australia) and the Privacy Act 2020 (Aotearoa New Zealand). This policy applies to all personal information collected, stored, used and disclosed by the College. | |
| **Enquiries & Application Submission** | |
| **Enquiries**  Phone: +61 2 9256 5444 (request call transfer to the Education Officer of Advanced Training in Palliative Medicine)  Email: [PalliativeMedTraining@racp.edu.au](mailto:PalliativeMedTraining@racp.edu.au)  **Submission**  Please ensure you have saved a copy for your records and email an electronically saved or clearly scanned copy to [PalliativeMedTraining@racp.edu.au](mailto:PalliativeMedTraining@racp.edu.au) (photos will not be accepted). Hard copy applications are not required. | |

**Training Committee in Palliative Medicine**

**Application for Entry into Advanced Training in Palliative Medicine**

**1. PERSONAL DETAILS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Trainee | | |  | |  | | | |
|  | | | SURNAME / FAMILY NAME | | GIVEN / FIRST NAME(S) | | | |
| Address | | |  | | | | | |
|  | | |  | | | | | |
| Phone number | | |  | | | | | |
|  | | |  | | | | | |
| 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 [PalliativeMedTraining@racp.edu.au](mailto:PalliativeMedTraining@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 Australian and New Zealand Society of Palliative Medicine (ANZSPM) | | | | | | | |
|  |  | | | | | | | |
| Date of birth | |  | | Gender | | | |  | |
|  | |  | | | |  |
| **Are you of Aboriginal, Torres Strait Islander or Māori origin?** | | No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, Māori  Māori iwi affiliation | | Member ID No (MIN) | | | |  | |
|  | | | |  | |
| *If you don’t know your MIN, leave it blank.* | | | | | |
| *For persons of both Aboriginal and Torres Strait Islander origin, mark both ‘yes’ boxes*. | | | | | | | | | |

**2 ENTRY REQUIREMENTS FOR THE AChPM TRAINING PROGRAM**

**2.1. Registration as a Medical Practitioner**

|  |  |  |
| --- | --- | --- |
| Are you a registered medical practitioner in Australia or New Zealand? | YES | NO |
|  | | |
| ***Documentation from the relevant Medical Board must be provided with this application*** | | |

**2.2 Training Status**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you hold FRACP undertaken in a speciality other than Palliative Medicine? | | Yes | No |
|  |  | | |
| Specialty |  | | |
|  |  | | |
| Date of Admission |  | | |
|  |  | | |

|  |  |
| --- | --- |
| Post FRACP training *(if applicable)* | |
|  |  |
| Specialty |  |
|  |  |
| Date of completion |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you hold Fellowship of another College or Faculty? | | | Yes | No |
|  |  | | | |
| Specialty | Pain Medicine (FFPMANZCA) | | |  |
| Anaesthetics (FANZCA) | | |  |
| Psychiatry (FRANZCP) | | |  |
| Emergency Medicine (FACEM) | | |  |
| Radiation Oncology (FRANZCR) | | |  |
| General Practice (FRACGP and FRNZCGP) | | |  |
| Rehabilitation Medicine (FAFRM) | | |  |
| Intensive Care Medicine (FCICM/JFICM) | | |  |
| Surgery (FRACS) | | |  |
| Obstetrics and Gynaecology (FRANZCOG) | | |  |
| Rural and Remote Medicine (FACRRM) | | |  |
|  |  |  | | |
|  | Date of Admission | /       / | | |
|  |  |  | | |
| ***Documentation from the relevant College/Faculty must be provided with this application*** | | | | |
|  |  | | | |

**3 ACADEMIC QUALIFICATIONS IN PALLIATIVE MEDICINE OR DIRECTLY RELATED FIELDS**

Provide details of doctorate or masters level degrees or graduate diplomas or graduate certificates, relevant to palliative medicine.

|  |  |  |  |
| --- | --- | --- | --- |
| Award | Institution | Length of Program | Year Conferred |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*Documentation from the relevant institution must be provided with the submission of this application*

# **4 ACCREDITATION OF PRIOR EXPERIENCE IN PALLIATIVE MEDICINE OR RELATED FIELDS**

Trainees wishing to apply for recognition of prior learning must complete an Application for Recognition of Prior Learning form, available for download at <http://www.racp.edu.au/trainees/education-policies-and-governance/education-policy>

Trainees should also refer to the College’s Recognition of Prior Learning Policy, available for download at <http://www.racp.edu.au/trainees/education-policies-and-governance/education-policy>.

**5 OTHER FACTORS TO STRENGTHEN APPLICATION**

Provide any other information you consider would enhance your application. For example, relevant practice or study, overseas experience, specialist interests or research projects.

|  |
| --- |
|  |

**6 CAREER GUIDANCE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Entry to Palliative Medicine Training is an important career commitment in terms of clinical training and continuing professional development. Have you received career guidance concerning a career in Palliative Medicine prior to submitting this application? | | | | | **YES** | **NO** |
|  |  | |  | |  | |
| Full Name of Mentor: |  | | | | | |
|  |  | |  | | | |
| Qualification(s): |  | | | | | |
| Full Address: |  | | | | | |
| Phone: (W) |  | Fax: (W) | |  | | |
| E-mail: |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Mentor’s Signature: |  | Date: |  |

**7 APPLICANT DECLARATION**

|  |  |
| --- | --- |
|  | 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/palliative-medicine) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy). |
|  | I have provided the relevant supporting documentation, including evidence of completion of fellowship of another College/Faculty and certificate of registration. |

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant’s Signature: |  | Date: |  |

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