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| RACP2016_OL | **Training Committee in Palliative Medicine** |
| **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 Handbooks](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs) 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/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  |
| **Enquiries & Application Submission** |
| **Enquiries**Phone: 1300 697 227 (+61 2 9256 5444) Email: 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 (photos will not be accepted). Please CC in your nominated supervisors for their records. Hard copy applications are not required. |

**Training Committee in Palliative Medicine**

**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 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) |
|  |  |
| 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

|  |
| --- |
|       |

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**2. TRAINEE DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region:** | [ ]  | Australia | [ ]  | New Zealand |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Division:** | [ ]  | Adult Medicine | [ ]  | Paediatrics & Child Health |
|  | [ ]  | Chapter |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Training Status:** | [ ]  | Advanced Training  | [ ]  | 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) | **Palliative Medicine** | 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.** | 1 |
| Duration of this training term (FTE months) |       | Commencing: |       | Ending: |       |
|  |  |  | dd/mm/yy |  | dd/mm/yy |
|  |  |  |  |  |  |
|  |  |  | [ ]  | Full time | or | [ ]  | Part time |
|  |  |  |  |  |  |
|  |  | If part time, percentage of full time training: |      % |
|  |  |  |  |
| **Approval sought for:** |
|  | [ ]  | 1. Inpatient/Hospice  |
| [ ]  | 2. Community  |
| [ ]  | 3. Hospital Consultation  |
| [ ]  | 4. Palliative Medicine Variable (trainees who commenced in 2016 and prior) |
| [ ]  | 4. Cancer Care Setting (trainees who commenced in 2017 and after) |
| [ ]  | 5. Oncology (trainees who commenced in 2016 and prior) |
| [ ]  | 5. Palliative Medicine Variable or Related Specialty (trainees who commenced in 2017 and after) |
| [ ]  | 6. Elective/Non-core |
|  |  |
| Post or position: |       |
| Hospital/Institution: |       |
| Address: |       |
|  |  |
| Describe the clinical experience to be obtained in this proposed term:  |       |
|  |  |
| **Clinical activities and responsibilities:** |
| Hours spent in clinical activities per week |       | Hours expressed as a percentage of total hours per week |      % |
|  |
|  |
| **Research activities:** |
| Hours given to research per week |       | Hours expressed as a percentage of total hours per week |      % |
|  |
|  Details of research topic:*(Attach detailed report if time spent in research is significant.)* |       |
|  |
| Give details of any papers you will be presenting during this period |       |
|  |
| List of publications planned |       |
|  |  |
| **TERM No.** | 2 (if applicable) |
| Duration of this training term (FTE months) |       | Commencing: |       | Ending: |       |
|  |  |  | dd/mm/yy |  | dd/mm/yy |
|  |  |  |  |  |  |
|  |  |  | [ ]  | Full time | or | [ ]  | Part time |
|  |  |  |  |  |  |
|  |  | If part time, percentage of full time training: |      % |
|  |  |  |  |
| **Approval sought for:** |
|  | [ ]  | 1. Inpatient/Hospice  |
| [ ]  | 2. Community |
| [ ]  | 3. Hospital Consultation  |
| [ ]  | 4. Palliative Medicine Variable (trainees who commenced in 2016 and prior) |
| [ ]  | 4. Cancer Care Setting (trainees who commenced in 2017 and after) |
| [ ]  | 5. Oncology (trainees who commenced in 2016 and prior) |
| [ ]  | 5. Palliative Medicine Variable or Related Specialty (trainees who commenced in 2017 and after) |
| [ ]  | 6. Elective/Non-core |
|  |  |
| Post or position: |       |
| Hospital/Institution: |       |
| Address: |       |
|  |  |
| Describe the clinical experience to be obtained in this proposed term:  |       |
|  |  |
| **Clinical activities and responsibilities:** |
| Hours spent in clinical activities per week |       | Hours expressed as a percentage of total hours per week |      % |
|  |
| **Research activities:** |
| Hours given to research per week |       | Hours expressed as a percentage of total hours per week |      % |
|  |
|  Details of research topic:*(Attach detailed report if time spent in research is significant.)* |       |
|  |
| Give details of any papers you will be presenting during this period |       |
|  |
| List of publications planned |       |

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 (if applicable) |
|  |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| am |       |       |       |       |       |
| pm |       |       |       |       |       |

**5. SUPERVISOR(S)**

*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.*

*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.***

**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: |       |

**Supervisor 3**

|  |  |
| --- | --- |
| 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 4**

|  |  |
| --- | --- |
| 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: |       |

**6. TRAINING ACTIVITIES**

**Teaching**

Please give details of teaching available to you and indicate frequency.

|  |  |
| --- | --- |
| Grand rounds: |       |
|  |  |
| Lectures: |       |
|  |  |
| Seminars ‘in house’: |       |
|  |  |
| Courses or conferences you plan to attend: |       |
|  |  |
| Do you teach others? |  |  |
|  |
| If yes, please indicate hours per week spent in teaching: |
| Undergraduates |       | Basic trainees  |       | Nursing staff  |       |
|  |

**7. PROJECT PLAN**

The Training Committee in Palliative Medicine requires advanced trainees to submit one project by the end of their final year of training. The Training Committee in Palliative Medicine does not accept projects submitted to other committees. Please provide details of your project

|  |  |
| --- | --- |
| Title of project: |       |
|  |  |
| Project supervisor: |       |
|  |  |
| Expected submission date: |       |
|  |  |
| Brief outline of project: |       |
|  |  |
| Progress for completion of project: |       |

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

|  |
| --- |
|       |

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

|  |
| --- |
|       |

**10. 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/palliative-medicine) and Education Policies. |
| **[ ]**  | 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.**