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| **Australasian Faculty of Rehabilitation Medicine** | |
| **Application for Prospective Approval of Advanced Training**  **PREP Program** | |
| **Important Information** | |
| This application form is for use by Advanced Trainees and Fellows who intend to undertake full or part time 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/adult-rehabilitation-medicine/prep-general-rehabilitation-medicine) and [Education Policies.](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policies)  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 of the 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 eight 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) | |
| **Enquiries & Application Submission** | |
| **Enquiries** | **Submission Process** |
| Email:  [Rehab@racp.edu.au](mailto:Rehab@racp.edu.au)  Phone:  +61 2 8076 6350 | **Via email to:** [Rehab@racp.edu.au](mailto:Rehab@racp.edu.au)  Please ensure 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.** **Incomplete applications will be returned to the trainee and will delay the approval process.** |

**Australasian Faculty of**

**Rehabilitation 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 Email |  | | | | |
| **NB:** The College will use email as the primary method to communicate with you throughout your Advanced Training. Please ensure that you can receive email from [rehab@racp.edu.au](mailto:rehab@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 [MyRACP.](https://my.racp.edu.au/) | | | | | |
| 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**

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| --- | --- | --- | --- | --- |
| **Region:** |  | Australia |  | Aotearoa New Zealand |
| **Division:** |  | Adult Medicine |  | Paediatrics & Child Health |
| **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.*

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| Primary committee  (most relevant to enclosed training rotations) | **General Rehabilitation** | Secondary committee  (other committee/s to be made aware of rotation details) |  |

**4. DETAILS OF TRAINING PROGRAM**

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| --- | --- | --- | --- | --- | --- |
| 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 6-month rotation.* | | | | |

*If you are in one position for 12 months, please complete both Term 1 and Term 2 sections, dividing your year into 6-month rotations. If you are completing two rotations, either at different sites, in different roles, or at different FTE, please separate details into Term 1 and Term 2. If you only have full details for a single rotation, only complete one Term.*

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| **TERM 1** | | |  | |
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| Training in the following subspecialty e.g., Neurological, Orthopaedics, Geriatric. | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | 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 | |
|  | | | |  | |
| Approval Sought For: | | | | | | | Core: | | | |  | | Non-core: | |  | |
|  | | | |  | |
| Post or position: | | | | | | |  | | | | | | | | | | | |
| Hospital/Institution: | | | | | | |  | | | | | | | | | | | |
| Address: | | | | | | |  | | | | | | | | | | | |

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| **TERM 2** | | |  | |
|  | | | | | | | | | | | | | | | | | | | | |
| Training in the following subspecialty e.g., Neurological, Orthopaedics, Geriatric. | | | | | | | | |  | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | |
|  | | 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 | |
|  | | | |  | |
| Approval Sought For: | | | | | | | Core: | | | |  | | Non-core: | |  | |
|  | | | |  | |
| Post or position: | | | | | | |  | | | | | | | | | | | |
| Hospital/Institution: | | | | | | |  | | | | | | | | | | | |
| Address: | | | | | | |  | | | | | | | | | | | |

**5. SUPERVISORS**

***Please note, both you and your supervisors must sign this application before it is submitted to the College. Supervisor signature is not required only when the Supervisor is copied into the email submission of the application to the College.***

*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.*

*Trainees are required to show previous supervisors’ reports to current supervisors in order to assist both trainees and supervisors with the development of relevant learning plans for the current training period. This requirement is not applicable if this is the first advanced training period.*

*The entire training rotation must be covered by the period of supervision. Supervision of one rotation may be undertaken by more than one supervisor, but each supervisor listed will have to contribute to the Supervisor’s Report.*

**Supervisor 1**

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| --- | --- |
| Full Name of Supervisor: |  |
| Qualification(s): |  |
| Phone: (W) |  |
| E-mail: |  |

|  |  |  |  |  |
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| Please specify the period of supervision: | Commencing |  | Ending: |  |
|  | dd/mm/yy | | dd/mm/yy |

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| --- | --- | --- | --- | --- |
|  | 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) |  |
| E-mail: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please specify the period of supervision: | Commencing |  | Ending: |  |
|  | dd/mm/yy | | dd/mm/yy |

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| --- | --- | --- | --- | --- |
|  | 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. TRAINEE DECLARATION** *(please tick boxes that apply)*

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|  | 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/adult-rehabilitation-medicine/prep-general-rehabilitation-medicine) and [Education Policies.](https://www.racp.edu.au/trainees/education-policies-and-governance/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. |

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

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