 Advanced Training

Rotation Amendment Form Respiratory and Sleep Medicine

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| **Important information** |
| Use this form to indicate changes to approved Advanced Training rotations due to the impact of the COVID-19 pandemic. Further information on the RACP response to the pandemic can be found on the [RACP website](https://www.racp.edu.au/news-and-events/covid-19).  For all other rotation amendments, please complete a new Advanced Training application (the form can be downloaded from the ‘Apply or re-register’ tab of your [specialty handbook](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs)) or contact your specialty.  Instructions:   1. Before you complete this form, please ensure you have read and familiarised yourself with the relevant [Advanced Training Program Requirements](http://www.racp.edu.au/trainees/advanced-training). 2. Once completed, email this form to your specialty email address as soon as possible. 3. The supervisor(s) of the amended rotation must be copied into the email submission of this form. |

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| **Privacy legislation** |
| The RACP complies with the requirements of the national Privacy Act 1988 (Cwlth) (Australia) and the Privacy Act 1993 (New Zealand) and has adopted the Australian National Privacy Principles as the guidelines for ensuring the protection of personal information in its care. This policy applies to all personal information collected, stored, used and disclosed by the College. Further details can be found on the RACP [website](https://www.racp.edu.au/docs/default-source/default-document-library/pol-privacy-personal-information.pdf?sfvrsn=2). |

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| **Trainee personal details** |
| |  |  |  | | --- | --- | --- | | Surname: |  | | | First/given name: |  | | |  | | | |  | | | | Member Identification Number (MIN): |  |  | | Primary Specialty Training Program: |  | | | Secondary Specialty Training Program(s): |  | | |

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| **Details of approved rotation to be amended** |
| Please complete a separate form for each rotation to be amended. |
| |  |  | | --- | --- | | Rotation name/type: |  | | Training setting: |  | | Start date: |  | | End date: |  | |

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| **Details of change to approved rotation** | | | | | |
| Has your rotation changed as a result of COVID-19? Y / N  *E.g. reduction in access to clinics due to the impact of COVID-19 or deployed to a COVID-19 team.* | | | | | |
| Dates of change of rotation/run: | | | | | |
| Did the deployment/change result in a move to a different training setting? Y / N  If yes, name of setting: | | | | | |
| Did the deployment/change result in a change to your approved supervisor(s)? Y / N  If yes, name of original supervisor(s):  Name of new supervisor(s): | | | | | |
| Please provide a brief outline of duties undertaken during this period. Include the main clinical responsibilities, patient mix, administrative responsibilities etc. (attach a separate page if required): | | | | | |
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| Have any COVID-related changes in your roster resulted in any perceived difficulty in meeting the requirements for either Respiratory or Sleep training regarding the recommended numbers of procedures or investigations that are ordinarily recommended to reach competency?  Have you been able to work with your Supervisors to ensure a mechanism to demonstrate competency if these numbers are not likely to be achievable? | | | | | |
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| Please provide details of your amended timetable: | | | | | |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **AM** |  |  |  |  |  |
| **PM** |  |  |  |  |  |

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| **Other circumstances**  Please outline any other circumstances that **as a result of COVID-19** have impacted your training (such as pregnancy, personal health, caregiver and family responsibilities, altered job roles): |
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| **Supervisor declaration**  Signatures are optional but if not signed, supervisors must be copied into the submission email.  This form cannot be accepted if the declaration box is not completed. |
| |  |  | | --- | --- | | I declare the information supplied on this form is complete and accurate | | | Supervisor name: |  | | Supervisor signature: |  | | Date: |  | |  | | | I declare the information supplied on this form is complete and accurate | | | Supervisor name: |  | | Supervisor signature: |  | | Date: |  | |

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| **Trainee declaration**  This form cannot be accepted if the declaration box is not completed. |
| |  |  | | --- | --- | | I have discussed this amendment with my supervisor/s and declare the information supplied on this form is complete and accurate. | | | Date: |  | |  | | |