|  |  |
| --- | --- |
| RACP2016_OL | **Training Committee****in Sexual Health 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 post-FRACP 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.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/sexual-health-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 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: shmedtraining@racp.edu.au**Submission** Please ensure you have saved a copy for your records and email an electronically saved or clearly scanned copy shmedtraining@racp.edu.au (photos will not be accepted). Please CC your nominated supervisors for their records. |

**Training Committee in**

**Sexual Health 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 shmedtraining@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/>. |
|  |
| 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region:**Where you completed Basic Training/ first Fellowship | [ ]  | Australia | [ ]  | New Zealand |

**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) |       | Secondary committee(other committee/s to be made aware of rotation details) |       |

**4. DETAILS OF THE PROPOSED TRAINING PROGRAM**

|  |  |  |
| --- | --- | --- |
| Year of Advanced Training: |  |  |
|  |
| Employing Institution: |       |
|  |
| Number of rotations indicated on this application: |       |  |
| [ ]  Full time or [ ]  Part-time | If part-time, percentage of full-time training: |  |
|       |
|  |

**Please select the component of training you are working in, and list the percentage and any further information if possible:**

|  |  |
| --- | --- |
| [ ]  Male Sexual Health |       |
| [ ]  Female Sexual Health |       |
| [ ]  Reproductive Health  |       |
| [ ]  HIV Medicine  |       |
| [ ]  Elective (please specify) |       |
| [ ]  Other (please specify) |       |

**4.1 TRAINING POSITIONS**

**Training Position 1**

|  |  |
| --- | --- |
| Full time equivalent in months |      mths |
| Period | Start Date |       | Finish Date |       |
| Hours in clinical activities per week |       |
| Hours in clinical activities expressed as a percentage of total working hours per week |      % |

|  |  |
| --- | --- |
| Name of Institution  |       |
| Type of Institution |       |
| Position held:  | Registrar [ ]  Other [ ]  If Other, please provide the details:       |

**Training Position 2**

|  |  |
| --- | --- |
| Full time equivalent in months |       mths |
| Period | Start Date |       | Finish Date |       |
| Hours in clinical activities per week |       |
| Hours in clinical activities expressed as a percentage of total working hours per week |      % |

|  |  |
| --- | --- |
| Name of Institution  |       |
| Type of Institution |       |
| Position held:  | Registrar [ ]  Other [ ]  If Other, please provide the details:       |

**Training Position 3**

|  |  |
| --- | --- |
| Full time equivalent in months |       mths |
| Period | Start Date |       | Finish Date |       |
| Hours in clinical activities per week |       |
| Hours in clinical activities expressed as a percentage of total working hours per week |      % |

|  |  |
| --- | --- |
| Name of Institution  |       |
| Type of Institution |       |
| Position held:  | Registrar [ ]  Other [ ]  If Other, please provide the details:       |

If training is undertaken in a combination of positions, please indicate a percentage of involvement in each position:

|  |  |  |
| --- | --- | --- |
|  | Percentage of training involved in position | Full time equivalent in months |
| Position 1:  |      % |       months |
| Position 2:  |      % |       months |
| Position 3:  |      % |       months |
| Other:  |      % |       months |

|  |  |
| --- | --- |
| TERM No. | 1 |
|   | Monday | Tuesday | Wednesday | Thursday | Friday |
| am |  |       |       |       |       |
| pm |       |       |       |       |       |
|       |

|  |  |
| --- | --- |
| TERM No. | 2 |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| am |       |       |       |       |       |
| pm |       |       |       |       |       |
|       |

**5. KNOWLEDGE AND SKILLS DEVELOPMENT**

**5.1 Formal Study Requirements**

**(a) Formal instruction in Fertility Regulation**

Completed (do not provide details if completed) [ ]  Completing this year [ ]  Completing in future [ ]

*Course being undertaken:*

If applying for approval of an alternative course, please list course name and institution:

Dates of study:

**(b) Formal instruction in HIV Medicine**

Completed (do not provide details if completed) [ ]  Completing this year [ ]  Completing in future [ ]

*Course:*  ASHM Short Course in HIV Medicine (mandatory)

Dates of study:

*Course:*  s100 Prescriber’s Course (mandatory)

Dates of study:

*Other advanced study in HIV Medicine being undertaken:*

Dates of study:

**(c) Formal instruction in Laboratory Methods**

Completed (do not provide details if completed) [ ]  Completing this year [ ]  Completing in future [ ]

*Course being undertaken for Lab Methods:*

If applying for approval of an alternative course, please list course name and institution:

Dates of study:

*Course being undertaken for Sexual Health Medicine:*

If applying for approval of an alternative course, please list course name and institution:

Dates of study:

 **(d) Formal instruction in Epidemiology**

Completed (do not provide details if completed) [ ]  Completing this year [ ]  Completing in future [ ]

Course bring undertaken:

If applying for approval of an alternative course, please list course name and institution:

Dates of study:

**5.2 Research / Academic Study**

**RESEARCH ACTIVITY 1**

|  |  |
| --- | --- |
| Specialty Eg. general medicine, gynaecology, urology, clinical pharmacology, dermatology, pain management, medical administration. |       |
| Full time equivalent in months |       months |
| Period | Start Date |       | Finish Date |       |
| Hours in research activities per week |       hours |
| Hours in research expressed as a percentage of total working hours per week |      % |

**RESEARCH ACTIVITY 2**

|  |  |
| --- | --- |
| Specialty Eg. general medicine, gynaecology, urology, clinical pharmacology, dermatology, pain management, medical administration. |       |
| Full time equivalent in months |       months |
| Period | Start Date |       | Finish Date |       |
| Hours in research activities per week |       hours |
| Hours in research expressed as a percentage of total working hours per week |      % |

**PROJECT 1**

|  |  |
| --- | --- |
| Name of project |       |
| Name of Institution  |       |
| Type of Institution  |       |
| Position held:  | Registrar [ ]  Other [ ]  If Other, please provide the details:       |

**PROJECT 2**

|  |  |
| --- | --- |
| Name of project |       |
| Name of Institution  |       |
| Type of Institution  |       |
| Position held:  | Registrar [ ]  Other [ ]  If Other, please provide the details:       |

5.3 Clinical Experience in:

|  |
| --- |
| **Sexual health medicine for ambulatory patients**      |
| **Practical day to day decision making with the patient**      |
| **The delivery of sexual health medicine services to the community and in clinics**      |
| **Consultations to other units of the hospital, particularly in a teaching hospital environment**      |
| **Research directed towards a higher degree (MD or PhD)**      |

**6. TRAINING ACTIVITES**

(a) Frequency of grand rounds per week

(**b) Details of seminar activity available ‘in house’**

|  |
| --- |
|  |

**(c) Details of conferences you plan to attend**

|  |
| --- |
|       |

**(d) Diagnostic techniques (if applicable)**

|  |
| --- |
|       |

**(e) Teaching**

Indicate hours per week spent in teaching:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| undergraduates |       |  | graduates |       |  | nursing staff |       |

 **(f) Research**

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

Details of any research activities

|  |
| --- |
| (A separate detailed report should be attached if the time spent in research is significant)      |

Give details of any papers you will be presenting during this period

|  |
| --- |
|       |

Please list any publications planned

|  |
| --- |
|       |

**(g) Project Proposal**

The objective of the project is to ensure that Trainees gain experience in the critical evaluation of scientific data. Please refer to the [*PREP Handbook*](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/sexual-health-medicine)*,* for information regarding types of project reports and other information.

**Nature of project (please ✓): (see** [**project guidelines**](https://www.racp.edu.au/trainees/advanced-training/advanced-training-programs/sexual-health-medicine)**)**

|  |  |
| --- | --- |
| [ ]  Research project |  |
| [ ]  Audit | [ ]  CPD Module |
| [ ]  Systematic review | [ ]  Other (specify)      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Working title of project:**

|  |
| --- |
|       |

|  |  |
| --- | --- |
| **Percentage contribution by trainee**  |      % |
| **Percentage performed by other contributors**  |      % |

**Please provide a brief description (300 words maximum) of the research:**

**Research Question**

**Background**

**Proposed Methodology**

**How results will be analysed**

**Proposed timeframe of project**

**Does this project require ethics approval? If not, why?**

|  |
| --- |
|       |
| *All completed projects requiring ethics approval* ***must*** *have a copy of approval by a relevant ethics committee attached.* |

Title(s) of **previous** projects submitted during training:

|  |
| --- |
|       |

**6. BRIEF OUTLINE OF TRAINING INTENDED SUBSEQUENT TO THIS YEAR**

|  |
| --- |
|       |

**7. 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 one supervisor for the period(s) of training indicated on this application form. Supervisors can submit composite Educational 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 (mandatory – Fellow of AChSHM)**

|  |  |
| --- | --- |
| 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 (optional)**

|  |  |
| --- | --- |
| 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. |
| **[ ]**  | I (supervisor) have provided my CV for consideration by the training committee (for non FAChSHM supervisors only) |
| Supervisor’s Signature: |       | Date: |       |

Project Supervisor

Trainees may nominate a separate Project Supervisor from their clinical Supervisor, for example in cases where the Trainee has different training Supervisors over a three-month term.

|  |  |
| --- | --- |
| Name of Project Supervisor |       |
| Supervisor’s qualification(s) |       |
| Address |       |

Mentor (recommended only)

Trainees are strongly recommended to nominate a mentor to provide guidance through their career development. A mentor can provide advice, coaching, encouragement, feedback and support and, if a problem arises, may be a useful advocate between you and your supervisors and the College. A mentor should not be a supervisor and need not be in the same area or hospital as long as regular contact is maintained.

Name of Mentor

Mentor’s phone no.

**8. 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/sexual-health-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. |

|  |  |  |  |
| --- | --- | --- | --- |
| 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.**