|  |  |  |
| --- | --- | --- |
| RACP2016_OL | **Advanced Training Committee**  **in Nephrology** (Australia) | |
| **Application for Prospective Approval of Advanced Training** | | |
| **Important Information** | | |
| 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/nephrology) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy).  Applications can span multiple training years but may not exceed 12 months per application. | | |
| **Closing Dates** | | |
| **Australia**  **15 February -** for approval of the first half or the entire training year  **31 August** - for approval of the second half of the training year. | | **New Zealand**  **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 will attract a late fee. Consideration of applications submitted after the deadline may be delayed. Late applications will not be accepted from one month after the published deadline. If your application is submitted late, you must attach an [Application for Consideration of Exceptional Circumstances](https://www.racp.edu.au/trainees/flexible-training-options/exceptional-circumstances) outlining the reasons for the delay. | | |
| **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 a Finance Officer by email [Accounts.Receivable@racp.edu.au](mailto:Accounts.Receivable@racp.edu.au) or call (+61) 2 9256 9629 or (+61) 2 9256 9621 to discuss the matter. | | |
| **Enquiries & Application Submission** | | |
| |  |  | | --- | --- | | **Australian Office** | **Submission Process** | | **Enquiries:** Email:  [Nephrology@racp.edu.au](mailto:Nephrology@racp.edu.au)  Phone:  +61 2 8247 6232 | **Via Email to:** [Nephrology@racp.edu.au](mailto:Nephrology@racp.edu.au)  Please ensure you have saved a copy for your records and email an electronically saved or  clearly scanned copy to the above email (photos will not be accepted). Please cc in your  nominated supervisors for their records.  **Via Post to:**  Education Services  The Royal Australasian College of Physicians  145 Macquarie Street  SYDNEY NSW 2000 AUSTRALIA | | | |

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**Advanced Training Committee in Nephrology** **(Australia)**

**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 [nephrology@racp.edu.au](mailto:nephrology@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 |  | Australia |  | New Zealand |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Division:** |  | Adult Medicine |  | Paediatrics & Child Health |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Training Status:** |  | **Advanced Training**  (completed Basic training and passed the FRACP Examination) |  | **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 both 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 two advanced training committees.*

|  |  |  |  |
| --- | --- | --- | --- |
| Primary committee  (most relevant to enclosed training rotations) | **Nephrology** | Secondary committee  (other committee to be made aware of rotation details) |  |

**4. DETAILS OF TRAINING PROGRAM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 rotation to a different site*  *If you are in one position for the whole period of training indicated on this application form, please provide further details under Term 1 only. If you are completing more than two terms during the period indicated on this application form* ***please duplicate this page and attach it to the application.*** | | | | |

*If you are in one position for the whole period of training indicated on this application form, please provide further details under Term 1 only. If you are completing more than two terms during the period indicated on this application form**please duplicate this page and attach it to the application.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TERM No.** | | | **1** | |
|  | | | | | | | | | | | | | | | | |
| Training in the following subspecialty  . | | | | | | | | |  | | | | | | |
|  | | | | | | | | |  | | | | | | |
| Core clinical, non-core clinical or research: | | | | | | | | |  | | | | | | |
|  | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | 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 |
|  | |  |
| Post or position: | | | | | | |  | | | | | | | |
| Hospital/Institution: | | | | | | |  | | | | | | | |
| Address: | | | | | | |  | | | | | | | |
| Appointment in:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Please provide a weekly timetable for your position(s), outlining what you are doing each day or use the template provided in section 5.** | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TERM No.** | | |  | |
|  | | | | | | | | | | | | | | | | |
| Training in the following subspecialty  . | | | | | | | | |  | | | | | | |
|  | | | | | | | | |  | | | | | | |
| Core clinical, non-core clinical or research: | | | | | | | | |  | | | | | | |
|  | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | Full time | or |  | | Part time | | | | | If part time, percentage of full time training: | | | % | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Duration of this training term (months): | | | | | | |  | | Commencing: | |  | Ending: |  | |
| dd/mm/yy | |
|  | |
| Post or position: | | | | | | |  | | | | | | | |
| Hospital/Institution: | | | | | | |  | | | | | | | |
| Address: | | | | | | |  | | | | | | | |
| Appointment in:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | % |  | % |  | % |  | % |  | % | | Public hospital | | Private hospital | | Public facilities in public hospital | | Private outpatient clinics within public hospital | | Other | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Please provide a weekly timetable for your position(s), outlining what you are doing each day or use the template provided in section 5.** | | | | | | | | | | | | | | |

**5. WEEKLY TIMETABLES**

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

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

**6. SUPERVISORS**

*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.***

*Supervisors are encouraged to attend workshops run by the College to inform them about the educational use of the PREP Tools which underpin the Curriculum.  Information about these workshops can be found on the* [*Supervisors Support*](https://www.racp.edu.au/fellows/supervision) *page of the College website.*

|  |
| --- |
| **TERM No. 1** |

**Supervisor One**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name of Supervisor: |  | | | |
| Qualification(s): |  | Accredited supervisor:  (*Yes / No / First time*) | |  |
| Full Address: |  | | | |
| Phone: (W) |  | Fax: (W) |  | |
| E-mail: |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please specify the period of supervision:** | Term(s): |  | Commencing: |  | Ending: |  |
|  |  |  | dd/mm/yy | | dd/mm/yy |

*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.*

**I (supervisor) have sighted the supervisors’ reports from previous training periods (if applicable) for this trainee.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

***Supervisor's Signature Date (dd/mm/yy) Trainee's Signature Date (dd/mm/yy)***

**Supervisor Two**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name of Supervisor: |  | | | |
| Qualification(s): |  | Accredited supervisor:  (*Yes / No / First time*) | |  |
| Full Address: |  | | | |
| Phone: (W) |  | Fax: (W) |  | |
| E-mail: |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please specify the period of supervision:** | Term(s): |  | Commencing: |  | Ending: |  |
|  |  |  | dd/mm/yy | | dd/mm/yy |

*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.*

**I (supervisor) have sighted the supervisors’ reports from previous training periods (if applicable) for this trainee.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

***Supervisor's Signature Date (dd/mm/yy) Trainee's Signature Date (dd/mm/yy)***

|  |
| --- |
| **TERM No.** |

**Supervisor One**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name of Supervisor: |  | | | |
| Qualification(s): |  | Accredited supervisor:  (*Yes / No / First time*) | |  |
| Full Address: |  | | | |
| Phone: (W) |  | Fax: (W) |  | |
| E-mail: |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please specify the period of supervision:** | Term(s): |  | Commencing: |  | Ending: |  |
|  |  |  | dd/mm/yy | | dd/mm/yy |

*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.*

**I (supervisor) have sighted the supervisors’ reports from previous training periods (if applicable) for this trainee.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

***Supervisor's Signature Date (dd/mm/yy) Trainee's Signature Date (dd/mm/yy)***

**Supervisor Two**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name of Supervisor: |  | | | |
| Qualification(s): |  | Accredited supervisor:  (*Yes / No / First time*) | |  |
| Full Address: |  | | | |
| Phone: (W) |  | Fax: (W) |  | |
| E-mail: |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please specify the period of supervision:** | Term(s): |  | Commencing: |  | Ending: |  |
|  |  |  | dd/mm/yy | | dd/mm/yy |

*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.*

**I (supervisor) have sighted the supervisors’ reports from previous training periods (if applicable) for this trainee.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

***Supervisor's Signature Date (dd/mm/yy) Trainee's Signature Date (dd/mm/yy)***

**7. TRAINING ACTIVITIES**

**Clinical Activities and Responsibilities**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of inpatients |  | Number of outpatient clinics |  | Number of ward rounds per week |  |
|  | | | | | |
| Specialty of clinic(s) |  | | | | |

Responsibilities at associated centres/peripheral hospitals (if applicable):

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hours in clinical activities per week |  | Hours expressed as a percentage of total hours per week | % | Frequency of grand rounds per week |  |

Details of seminar activity available ‘in-house’:

|  |
| --- |
|  |

**Diagnostic Techniques** (if applicable)

|  |  |
| --- | --- |
| **Technique** | **Number** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Conferences/Scientific Meetings**

Details of conferences you have attended:

|  |  |
| --- | --- |
| **Month** | **Conference** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Details of conferences/scientific meetings you propose to attend:

|  |  |
| --- | --- |
| **Month** | **Conference** |
|  |  |
|  |  |
|  |  |
|  |  |

**Teaching**

Indicate hours per week to be spent in teaching

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Undergraduates |  | Basic trainees |  | Nursing staff |  |

**Research**

*Please note that you are required to submit an abstract of a published article and/or a copy of a presentation given at the ANZSN Annual Scientific Meeting (or equivalent) by the end of your training.*

Details of 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/have presented during this period:

|  |
| --- |
|  |

Please append list of all publications under the headings original articles (including in press), conference papers, abstracts, chapters, lay press:

|  |
| --- |
|  |
|  |

**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/nephrology) and [Education Policies](https://www.racp.edu.au/trainees/education-policies-and-governance/education-policy). |
|  | 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: |  |

**12. Provision of information to specialty society**

**Specialty Society contact list**

Specialty societies are key stakeholders in physician training. Specialty societies would like to be able to send Advanced Trainees in related training programs information about the society as well as updates and invitations to social events. To facilitate this activity, the College will send the specialty societies a contact list (name and email address) of any trainees undertaking the Advanced Training program associated with the specialty society. Please tick the following box if you wish to opt out of this information-sharing process and your details will be removed from the contact list provided to the society.

I do not authorise my name and email address to be sent to the specialty society

**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.**