



Provisional fellowship training

Individualised positions in an overseas or non-ANZCA accredited site application

This application form should be used by trainees to apply for provisional fellowship study plans in an overseas or a non-ANZCA accredited training site. Please note, it is your responsibility to check the registration and local medical council for overseas placements before applying to ANZCA.

Personal details

College ID

First name

Surname

Eligibility

Have you completed the advanced training (AT) requirements? Yes No

What is the date you completed or expect to complete AT?

Training site details

Name of hospital or training site

State

Country

Is the training site approved for training? Yes No

If so, name of college or training body who accredit the training site

Specialty (for example anaesthesia, intensive care)

Training Start date End date

Full / Part time (If part time please complete a part-time training application) FTE

Name of director or contact person

Email

Phone

How is this job different from your previous training experience?

How do you see this position helping you to transition to independent practice?

Provide details of how you will spend at least 10 per cent of your provisional fellowship time completing clinical support activities. Activities may include: administration, research, audit, teaching and other clinical quality assurance activities.

Please note, clinical support activities should be recorded under time in TPS.

ANZCA Supervisor nomination

College ID

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Name of Supervisor _____

Training site _____

Email _____

As the nominated ANZCA Supervisor, I can confirm my willingness provide support and advice to the trainee and to the supervising consultant during this term. I understand I will require access to the TPS and will be required to validate assessments as appropriate. I am familiar with the trainee and the requirements of the ANZCA training program.

Signature _____

Date _____

Declaration of trainee

I solemnly declare that the statements made in this application are true and accurate.

Signature _____ Date _____

To be completed with the supervisor of the position

Characteristics of position

Will the trainee have opportunities to spend at least 10% of his or her time performing clinical support activities in any or all of the following areas?

<i>Research activity:</i>	Yes	No
<i>Audit activity:</i>	Yes	No
<i>Teaching activity:</i>	Yes	No
<i>Administration:</i>	Yes	No
<i>Other:</i>	Yes	No

Will the position be at least 20% clinical time? Yes No

Will clinical time be in clinical anaesthesia? Yes No

If no, please provide details of other clinical time _____

What is the availability of the following sub-specialities at this hospital?

(Please provide list/session numbers per week.)

Acute pain	#	_____
Cardiothoracic	#	_____
Neurosurgery	#	_____
Obstetrics	#	_____
Paediatrics	#	_____
Perioperative medicine	#	_____
Regional	#	_____
Retrieval	#	_____
Trauma	#	_____
Other (please specify) _____	#	_____

What is the approximate case load of the hospital or unit? # _____
(Number of theatre cases, deliveries, clinic attendances, etc.)

Will the trainee manage lists independently with support available? Yes No

If yes, how many lists per week will the trainee manage independently with support available? _____

How many junior trainees will the trainee be required to supervise at any time? _____

Please outline levels of supervision available in and out of hours:

How will workplace based assessments be managed? (The minimum requirements are two CbDs and one MSF)

How will this position assist in the transition from the provisional fellowship training to independent practice?

Other comments relevant to this post:

Session planner

Please complete the below session planner or attach a copy of the weekly session planner. This should not be a department roster

		Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	AM					
	PM					
Week 2	AM					
	PM					

Supporting documents

- Please attached a copy of your position description
- Please attach a copy of employment contract

Supervisor Details

First name _____

Surname _____

Degree / Qualification _____

Email _____

Mobile _____

Workplace-Based Assessors

You may nominate as many workplace-based assessors as you wish.

Assessor 1:

Title _____ First name _____

Surname _____

Email _____

Mobile _____

Assessor 2:

Title _____ First name _____

Surname _____

Email _____

Mobile _____

Assessor 3:

Title _____ First name _____

Surname _____

Email _____

Mobile _____

Assessor 4:

Title _____ First name _____

Surname _____

Email _____

Mobile _____

Declaration of Supervisor

I agree to fully participate in all aspects of the ANZCA vocational training program and will ensure that all required assessments will be completed. I will also provide ANZCA with all required training information, for example, workplace-based assessments

Signature _____ Date _____

Send your completed form and accompanying documents to the college:

ANZCA Training
Email: training@anzca.edu.au

For any queries, please email or contact us at +61 3 9510 6299.