**Individual Training Placement**

**Purpose**

This form is used to apply for College approval of a training placement in a post that does not meet one of the mandatory training requirements, for example a six-month mental health placement, or a placement in a MM1 location.

The form **may be** used for CGT post accreditation for an individual registrar for up to six months when ongoing accreditation is not required (including an Overseas placement).

The form **may not** be used to apply for accreditation of an AST for an individual registrar, the [AST Post Accreditation](https://www.acrrm.org.au/docs/default-source/all-files/ast-application-for-accreditation.docx?sfvrsn=5c3c60ec_14) form must be used to apply for provisional accreditation.

**Instructions**

The placement must be part of the registrar’s training plan and be supported by the training organisation prior to applying to the College. The form is to be saved in word and completed form sent to [training@acrrm.org.au](mailto:training@acrrm.org.au)

Please mark the Policy which is relevant to the application.

[ACRRM Training Placement Policy](https://www.acrrm.org.au/resources/training/policies)

[ACRRM Overseas Training Placement Policy](https://www.acrrm.org.au/resources/training/policies)

[ACRRM Medicare Provider Number Policy](https://www.acrrm.org.au/resources/training/policies)

[AGPT Rural Generalist Policy 2020](https://www.health.gov.au/resources/publications/agpt-program-rural-generalist-policy-2020)

[AGPT Transfer Policy 2020](https://www.health.gov.au/resources/publications/agpt-program-transfer-policy-2020)

Other, provide details

**Personal details**

|  |  |
| --- | --- |
| Registrar name |  |
| Training Organisation |  |
| ACRRM membership number |  |
| Phone number |  |
| Email address |  |
| Date of application |  |

**Request information**

|  |
| --- |
| What is being requested? |
|  |
| Reason for the request? |
|  |
| Does this placement meet any of the mandatory training program requirements?  Yes  No |
| If Yes, which training program requirement/s |
|  |
| If No, which [Curriculum Learning Area](https://www.acrrm.org.au/resources/training/curriculum) does this placement provide training in eg Mental Health |
|  |

|  |  |  |
| --- | --- | --- |
| Detail below your outstanding Training Program Requirements and when and where/how they will be met, if this placement is approved | | |
| Outstanding requirement/s | When will it be met | Where/How will it be met |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Training post details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Training facility name |  | | | | |
| Address |  | | | | |
| City |  | | | | |
| State |  | Post Code |  | MMM |  |
| Telephone |  | Email |  | | |
| Training accreditation/s held by facility (e.g. ACRRM, RACGP, RACP, ACEM) |  | | | | |

**Supervisor details**

|  |  |  |
| --- | --- | --- |
| Supervisor name |  | |
| Supervisor qualification/s |  | |
| Supervisor accreditations held by supervisor (e.g. RACGP, RACP) |  | |
| Is the supervisor | Onsite | Off site |
| If offsite provide details |  | |

**Training placement details** *(start and end dates requested for approval)*

|  |  |
| --- | --- |
| Placement start date |  |
| Placement end date |  |
| Number of hours per week |  |
| Detail of placement e.g. wards/departments  *(must include the roster, if working in more than one department)* |  |
| Position title  *(must include a position description if working in a hospital)* |  |

**Training Organisation declaration**

I declare that this placement has been discussed with the above-mentioned registrar and provide support for this application for an individual training placement as per the relevant policy*.*

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Comments |  |
| Date |  |

**Registrar declaration**

I hereby declare that the information provided by me on this form is true and accurate.

I have read and agree to abide by the [College's Privacy Policy](https://www.acrrm.org.au/privacy)

I have discussed this placement with my medical educator

|  |  |
| --- | --- |
| Name |  |
| Date |  |

**College**

For Office Use only

|  |  |
| --- | --- |
| Training Officer | |
| Placement supported | Yes  No |
| Name |  |
| Date |  |
| Comments |  |
| Director of Training | |
| Approved | Yes  No |
| Name |  |
| Date |  |
| Comments |  |