**Specialist Pathway Application**

**Purpose**

This form is for specialist international medical graduates to apply for assessment of comparability to an Australian trained Fellow of the Australian College of Rural and Remote Medicine.

**Completing your application**

It is important that your read the [Specialist Pathway Guide](https://www.acrrm.org.au/docs/default-source/all-files/specialist-pathway-guide.pdf?sfvrsn=94a69ec3_4) before starting your application. This application must be typed. Handwritten applications will not be accepted. All supporting documents must be scanned and clearly named.

To submit the application [create an account](https://www.acrrm.org.au/membership/discover-membership/join) with the College and upload to ‘My Documents’ section of ‘My College’ dashboard, accessible from the [College website](https://www.acrrm.org.au/home). Once the application is uploaded, email [img@acrrm.org.au](mailto:img@acrrm.org.au) to notify staff.

**Application type**

Specialist Pathway

Type (selection one only):  Specialist Recognition  Area of Need  Combined

OR

Ad eundem gradum

Qualification:  FDRHMNZ  FRNZCGP  CFPC

**Applicant details**

|  |  |
| --- | --- |
| Family name (surname) |  |
| Given name/s |  |
| Address |  |
| State |  |
| Postcode / Zip code |  |
| Country |  |
| Phone number |  |
| Email address |  |

**Name change / variation**

Is the name shown above the same as that shown on all the supporting documents?

Yes  No

If NO, you are required to provide certified documentary evidence of your change of name. If submitting a statutory declaration, ensure that all variations are explained and state by which name you wish to be known for specialist assessment purposes.

**Primary source verification**

|  |  |
| --- | --- |
| EPICS number |  |
| USMLE number |  |
| AMC candidate number |  |

**Specialist registration**

Do you hold specialist registration?

Yes  No

If Yes, provide a copy of your certificate and if the medical register is public, provide a web link below.

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**Restrictions on medical practice**

Are you subject to any restrictions or limitations on your medical practice under any law or regulation?

Yes  No

If Yes, please supply details

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Have you been charged or convicted of a criminal offense (other than minor traffic or other trivial offenses)?

Yes  No

If Yes, please supply details

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**Rural experience**

Detail your rural experience, where you have provided clinical care away from ready access to specialist medical, diagnostic and allied health services. A minimum of three years is required since achieving your specialist qualification. Provide supporting information eg letter/s from employer/s and/or colleague/s or employment record/s.

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| --- | --- | --- | --- | --- |
| Year employment commenced | Length of employment (in months) | Hours per week | Location | Name and type of health service (eg general practice, hospital) |
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**Rural Generalist competencies**

Comparability is assessed against the domains and competencies of a Rural Generalist Medical Practitioner. Refer to the [Rural Generalist Curriculum](https://www.acrrm.org.au/docs/default-source/all-files/rural-generalist-curriculum_final.pdf?sfvrsn=b0fe42c8_4) for further information on these criteria.

In no more than 200 words per criterion describe how you meet each of the following Domains. You may reference the relevant sections of your CV for further detail.

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| Domain 1 | Provide expert medical care in all rural contexts |
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| Domain 2 | Provide primary care |
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| Domain 3 | Provide secondary medical care |
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| Domain 4 | Respond to medical emergencies |
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| Domain 5 | Apply a population health approach |
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| Domain 6 | Work with Aboriginal, Torres Strait Islander, and other culturally diverse communities to improve health and wellbeing |
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| Domain 7 | Practise medicine within an ethical, intellectual and professional framework |
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| Domain 8 | Provide safe medical care while working in geographic and professional isolation |
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A Rural Generalist is required to identify and acquire extended knowledge and skills as may be required to meet the healthcare needs of the local population (Competency 8.7).

Have you extended your knowledge and skills in any of the following areas?

|  |  |  |
| --- | --- | --- |
| Indigenous Health | Academic Practice | Adult Internal Medicine |
| Anaesthetics | Emergency Medicine | Mental Health |
| Obstetrics & Gynaecology | Paediatrics | Palliative Care |
| Population Health | Remote Medicine | Surgery |
| Other (please specify) | | |
|  | | |

If you have extended your knowledge and skills, provide further information by answering the questions relating to extended practice below.

Detail how you have used your area of extended knowledge and skills in the communities where you have lived and worked.

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Detail any training or qualifications relevant to this area of extended practice and provide a copy of the qualification/s.

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Detail any Clinical Privileges relevant to this area of extended practice and provide a copy of the Clinical Privileges letter/s?

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Detail any projects or papers presented relevant to this area of extended practice and provide a copy of the project/s and/or presentation/s.

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Detail any community development or similar groups that you have been a part of, in relation to your area of extended practice.

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**Supporting documentation**

Mark below, documentation included with the application. Documentation in the mandatory section is required with all applications.

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| --- | --- |
| **Mandatory** | |
|  | Proof of identity |meeting [AHPRA requirements](https://www.ahpra.gov.au/Registration/Registration-Process/Proof-of-Identity.aspx) |
|  | Curriculum vitae | meeting [AHPRA requirements](https://www.ahpra.gov.au/Registration/Registration-Process/Standard-Format-for-Curriculum-Vitae.aspx) or using [College CV proforma](https://www.acrrm.org.au/docs/default-source/all-files/cv-pro-forma.doc?sfvrsn=540b90eb_12) |
|  | Specialist training| completion of training report, course certificates, exam results, workplace-based assessments, supervisor reports, logbooks, research papers, as relevant to your training program (not required for CFPC & FRNZCGP holders) |
|  | Rural experience | letter/s from employer/s and/or colleague/s or employment record/s demonstrating three or more years rural experience since specialist registration |
|  | Continuing professional development program | compliance certificate for program and/or summary of activities, **do not** provide certificates for individual events |
|  | Offer of employment | letter |
|  | Application for Placement and Supervisor Approval/Accreditation [form](https://www.acrrm.org.au/fellowship/other-avenues/specialist-pathway). |
| **If applicable** | |
|  | English language proficiency |evidence(see [AHPRA requirements](https://www.ahpra.gov.au/Registration/Registration-Standards/English-language-skills.aspx)) |
|  | Name change | evidence |
|  | Specialist registration| certificate |
|  | Area of Need | certificate |
|  | Emergency courses | certificates within last 5 years |
|  | Procedural practice | currentcredentialing or clinical privileging |
|  | Other qualifications | certificates |

List any additional supporting documents below.

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**Declarations**

**Privacy notice**

I understand the Australian College of Rural and Remote Medicine ("the College") collects, stores and discloses my personal information for the purposes of providing training programs, for research or statistical purposes and to promote services which the College considers may be of interest to me. This information may be collected directly from me in my dealings with the College. To fulfil the purposes set out above, my personal information may also be collected from or passed onto external bodies which usually includes medical colleges, government organisations and associated training providers, or as otherwise permitted or required by law.

Further information about the collection of personal information is available in the [College's Privacy Policy](https://www.acrrm.org.au/footer/privacy). The Privacy Policy contains information about how you may access and seek correction of your personal information and how you can complain about a breach of the Australian Privacy Principles.

I agree to these terms and conditions and have read the Privacy Policy.

If you wish ACRRM to liaise with a third party regarding your application, please complete the Third Party Authority section below.

**Declaration by applicant**

|  |  |
| --- | --- |
| Full name |  |
| Date |  |

I hereby solemnly declare that:

I am the person identified in this application

I am the person who has signed below

I have familiarised myself with the requirements, procedures and policies as set out in relevant Medical Board Australia and ACRRM publications

The statements made, and the information provided in this application form and in the supporting documents are true and accurate

Signature of person making the declaration

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**Third Party Authority**

Under the Privacy Act 1988 (Cth), ACRRM is not permitted to disclose personal information about an applicant to a third party (eg a relative, friend or agent) without the consent of the applicant. See the [College's Privacy Policy](https://www.acrrm.org.au/footer/privacy).

An applicant may authorise a third party (agent) to communicate and/or act on their behalf by completing the following details.

**Applicant authorisation**

|  |  |
| --- | --- |
| Full name |  |
| Date of birth |  |
| Contact number |  |
| Email address |  |

I authorise my agent

|  |  |
| --- | --- |
| Full name |  |

to

Communicate with ACRRM verbally and in writing on my behalf regarding the processing and progress of my application.

Communicate with ACRRM on my behalf regarding the results of relevant assessments.

Undertake any other action reasonably necessary for the processing of my application on my behalf, except withdrawal forms/letters which must be completed by the applicant.

|  |  |
| --- | --- |
| Applicant signature |  |
| Date |  |

**Agent consent**

|  |  |
| --- | --- |
| Full name |  |
| Company name |  |
| Address |  |
| State |  |
| Postcode / Zip code |  |
| Country |  |
| Contact number |  |
| Email address |  |

I consent to act as an agent of the applicant listed above.

|  |  |
| --- | --- |
| Agents signature |  |
| Date |  |