POSITION DESCRIPTION - **GENERAL PRACTITIONER**

This position description is to be completed **electronically by the practice** and in full when seeking to appoint an International Medical graduate to a general practice position. It will be used by the Medical Board of Australia and its agent for **pre-employment structured clinical interview** and **registration** processes.

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| **PART A – INTERNATIONAL MEDICAL GRADUATES (IMG) DETAILS** | | | | | | | | | | | | | |
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| 1. | Family Name |  | | | | | | | | | | | |
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| 2. | Given Name |  | | | | | | | | | | | |
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| 3. | Detail the **qualifications, knowledge, skills, experience and postgraduate training** the IMG requires to perform this role (e.g. CPR certificate, ALS certificate) | | | | | | | | | | | | |
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| **PART B – POSITION DETAILS** | | | | | | | | | | | | | |
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| 4. | Name and full address of **general practice/s** where the IMG will be employed | | | | | | | | | | | | |
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| 5. | Type of practice | | | | | | | | | | | | |
|  | Individual | | | | Corporate | | | | After hours | | | | |
|  | Deputising service | | | | Aboriginal service | | | | Locum practice | | | | |
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| 6. | Is this practice(s) currently operating? | | | | | | | | Yes | | | | No |
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| 7. | If no, when will the practice/s commence operations? | | | | | | | | | | | | |
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| 8. | Operating days and hours of the practice/s | | | | | | | | | | | | |
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| 9. | IMGs days and hours of work including any on-call or after hours for the practice/s | | | | | | | | | | | | |
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| 10. | Will there be a probationary period, If yes, specify dates (e.g. 1 Apr - 30 Sep 21) | | | | | | | | | | | | |
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| 11. | Provide details of ALL MEDICAL practitioners working in the practice/s  **Alternatively provide a sample roster of a one week period** | | | | | | | | | | | | |
|  | Name | | | Days  (Mon, Tues, Fri) | | | Hours  (8.30am to 5.00pm) | | | | Practice/s | | |
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| 12. | Provide details of other staff working in the practice/s | | | | | | | | | | | | |
|  | Roles (e.g. reception/admin staff, registered nurses, other health professionals) | | | | | | | | | | | Number | |
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| **PART C – DETAILS AND REQUIREMENTS OF THE POSITION** | | | | | | | | | | | | | |
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| 13. | Provide a **general outline of the requirements of this role** (e.g. *to provide comprehensive medical care; including prevention, treatment and rehabilitation…*) | | | | | | | | | | | | |
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| 14. | Detail the nature of the **clinical requirements** of this role (e.g. ***medical diagnoses and treatment*** *of (e.g. respiratory diseases);* ***procedural tasks*** *(e.g. vaccination, ECG interpretation, pulmonary function test);* ***surgical procedures*** *(e.g. suturing lacerations, incision and drainage of abscess, excision of skin lesions);* ***aged care****;* ***obstetrics*** *and* ***gynaecology****;* ***anaesthetics****; emergency;* ***mental health****;* ***documentation*** *(e.g. medico-legal reports)* | | | | | | | | | | | | |
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| 15. | Detail how often your practice services the following patient categories | | | | | | | | | | | | |
|  | **Patient category** | | **Often** | | | **Occasionally** | | | | **Rarely** | | | |
|  | Indigenous | |  | | |  | | | |  | | | |
|  | Multicultural | |  | | |  | | | |  | | | |
|  | Aged Care | |  | | |  | | | |  | | | |
|  | Children | |  | | |  | | | |  | | | |
|  | Adolescents | |  | | |  | | | |  | | | |
|  | Mental Health | |  | | |  | | | |  | | | |
|  | Chronic Disease | |  | | |  | | | |  | | | |
|  | Obstetrics | |  | | |  | | | |  | | | |
|  | Other – Specify below (e.g. industrial injuries) | | | | | | | | | | | | |
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| 16.\* | Select the **offsite services** offered by the practice and indicate which of these services the IMG may be required to undertake **for the nominated level of supervision** | | | | | | | | | | | | |
|  | **Services** | | | | | **Practice** | | **IMG** | | | | **Accompanied by supervisor** | |
|  | Aged care or nursing home visits | | | | |  | |  | | | |  | |
|  | Home visits | | | | |  | |  | | | |  | |
|  | Prison visits | | | | |  | |  | | | |  | |
|  | Hospital - on call responsibilities | | | | |  | |  | | | |  | |
|  | Hospital - inpatient care | | | | |  | |  | | | |  | |
|  | Hospital - accident and emergency | | | | |  | |  | | | |  | |
|  | Other (please specify below | | | | |  | |  | | | |  | |
|  | \*Please complete Question 34 if indicated that the IMG will be participating in offsite services. | | | | | | | | | | | | |
| **PART D – LOCAL ENVIRONMENT AND HEALTH FACILITIES** | | | | | | | | | | | | | |
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| 17. | Provide an **overview** of the local environment where the practice is located *including your* ***RA classification****;* ***population******of the town; distance/travel time to the nearest ambulance station;*** *Primary Health Networks; schools and other facilities; details of local communities; cultural and linguistic diversity and environmental factors e.g., – climate* | | | | | | | | | | | | |
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| 18. | Provide an **overview** of the **nearest hospital** including ***name of hospital (& District); distance from practice*** *and* ***time it would take to transfer patient*** *and nature of transport;* ***general range of medical services provided****; resources/services/infrastructure available* | | | | | | | | | | | | |
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| 19. | Provide an **overview** of the **nearest tertiary hospital** including ***name of hospital (& District); distance from practice*** *and* ***time it would take to transfer*** *patient and nature of transport* | | | | | | | | | | | | |
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| 20. | Provide details of **other services** co-located with or provided by the practice *e.g. x-ray unit; pathology service; allied health professionals* | | | | | | | | | | | | |
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| **PART E – SUPERVISION ARRANGEMENTS** | | | | | | | | |
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| 21. | Select the level of supervision for this position *(please indicate ONE only)* | | | | | | | |
|  | **Level 1**  The supervisor takes direct and principal responsibility for each individual patient.   1. The supervisor must be physically present at the workplace at all times when the IMG is providing clinical care. 2. The IMG must consult their supervisor about the management of all patients at the time of the consultation and before the patient leaves the practice. 3. Supervision via telephone contact or other telecommunications is not permitted. | | | | | | |  |
|  | **Level 2**  The supervisor shares with the IMG, responsibility for each individual patient. The supervisor must ensure that the level of responsibility that the IMG is allowed to take for patient management is based on the supervisor’s assessment of the IMG’s knowledge and competence.   1. Supervision must be primarily in person – the supervisor must be physically present at the workplace a minimum of 80% of the time that the IMG is practising. Where the supervisor is not physically present, they must always be accessible by telephone or video link. 2. The IMG must inform their supervisor on a daily basis about the management of individual patients. | | | | | | |  |
|  | **Level 3**  The IMG takes primary responsibility for each individual patient**.**   1. The supervisor must ensure that there are mechanisms in place for monitoring whether the IMGs is practising safely. 2. The IMG is permitted to work alone provided that the supervisor is contactable by phone or video link. | | | | | | |  |
|  | **Level 4**  The IMG takes full responsibility for each individual patient.   1. The supervisor must oversee the IMG’s practice. 2. The supervisor must be available for consultation if the IMG requires assistance. 3. The supervisor must periodically conduct a review of the IMG’s practice. | | | | | | |  |
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| **Primary and secondary supervisor details** | | | | | | | | |
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| 22. | Provide the details of the proposed **primary supervisor** | | | | | | | |
|  | Name | | AHPRA Registration Number and Type | | Contact details  (Phone and email) | | | |
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| 23. | Provide a brief background summary of the **primary supervisor** | | | | | | | |
|  | Qualifications | | |  | | | | |
|  | Experience | | |  | | | | |
|  | Teaching/mentoring/supervision | | |  | | | | |
| 24. | Provide work arrangements of primary supervisor | | | | | | | |
|  | Days | Hours | | | | Practice/s | | |
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| 25. | Is the proposed **primary supervisor** currently supervising any other doctors? | | | | | | | |
|  | Yes – please provide further details below | | | | | | | |
|  | No – no action required | | | | | | | |
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|  | Name | | AHPRA Registration Number | | | | Level of supervision | |
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| 26. | Provide the details of the proposed **secondary supervisor** | | | | | | | |
|  | Name | | AHPRA Registration Number and Type | | Contact details  (Phone and email) | | | |
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| 27. | Provide a brief background summary of the **secondary supervisor** | | | | | | | |
|  | Qualifications | | |  | | | | |
|  | Experience | | |  | | | | |
|  | Teaching/mentoring/supervision | | |  | | | | |
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| 28. | Provide work arrangements of secondary supervisor | | | | | | | |
|  | Days | Hours | | | | Practice/s | | |
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| 29. | If no secondary supervisor/s nominated provide an explanation why? | | | | | | | |
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| 30. | If no secondary supervisor/s nominated provide details of supervision arrangements if primary supervision is unavailable e.g. planned or unplanned leave | | | | | | | |
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| **Supervised practice plan** | | | | | | | | |
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| 31. | Learning objective and recommended training/further professional development | | | | | | | |
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| 32. | Availability of other senior staff/supervisors for assistance and how will the IMG seek assistance | | | | | | | |
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| 33. | Frequency, purpose and method of meetings with principle supervisor and types of meetings (i.e. face to face, teleconference etc.) | | | | | | | |
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| 34. | Provide details of the supervision arrangements of offsite services referred to Question 16 | | | | | | | |
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| 35. | Provide details of how the IMG will participate in review of his/her clinical practice; participation in ongoing medical education and professional development and maintain his/her professional competence | | | | | | | |
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**Only complete if applying for Level 3 or Level 4 supervision**

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| 36. | Provide details of the availability of the nominated supervisor/s | | |
|  | **Availability of supervisor** | **Normal Hours** | **After Hours** |
|  | Within the local district | Yes  No | Yes  No |
|  | Travel time to the practice | Time: | Time: |
|  | Available via telephone | Yes  No | Yes  No |

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| **PART F – ORIENTATION TO THE PRACTICE/S** | |
| Provide **details** and **timelines** of how the IMG will be oriented into the Australian healthcare system across the following aspects: | |
| 37. | General |
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| 38. | Orientation to the Australian healthcare system |
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| 39. | Orientation to the hospital/practice |
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| 40. | Orientation to legislation and professional practice |
|  |  |
|  |  |
| 41. | Professional development |
|  |  |
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| 42. | Cultural diversity and social context of care |
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| 43. | Other |
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| **Return to practice plan** | | | | | |
| *For more information refer to the Medical Board’s Guidelines* | | | | | |
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| 44. | Has the IMG been out of practice for more than 3 years? | | | | |
|  | Yes – please attach a copy of the IMG’s completed Return to Practice form | | | | |
|  | No – no action required | | | | |
| **PART G – REGISTRATION TYPE** | | | | | |
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| 45. | Please confirm the type of registration being sought for the nominated applicant | | | | |
|  |  | Limited Registration –  Area of Need | | Complete Part H | |
|  |  | Limited Registration –  Postgraduate training or supervised practice | | Please attach a complete Training Plan form | |
|  |  | Provisional Registration | |  | |
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| **PART H – ELIGIBILITY TO RECRUIT AN IMG** | | | | | |
| **Area of Need and District Workforce Shortage or meets exemption criteria**  Please note that all recruitment of International Medical Graduate’s (IMG) needs to comply with the requirements of the Medical Board of Australia by working within a practice that has Area of Need and District Workforce Shortage or meets exemption criteria.  I/we certify that the practice for which this applicant is applying for holds: | | | | | |
|  | Area of Need and District of Workforce Shortage; or | | | | |
|  | Meets the exemption criteria. | | Please specify: | |  |
|  |  | | | | |
|  | Signature of Declarer | |  | | |
|  | Name (please print) | |  | | |
|  | Position | |  | | |
|  | Contact telephone number | |  | | |
|  | Date | |  | | |

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| **PART I – CERTIFICATION** | | |
| I/we certify that the above position description accurately reflects the nature of the position. | | |
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|  | **Signature of Employer** |  |
|  | Name (please print) |  |
|  | Position |  |
|  | Contact telephone number |  |
|  | Date |  |
|  |  | |
|  | **Signature of Supervisor** |  |
|  | Name (please print) |  |
|  | Position |  |
|  | Contact telephone number |  |
|  | Date |  |
|  |  | |
|  | **Signature of Applicant** |  |
|  | Name (please print) |  |
|  | Contact telephone number |  |
|  | Date |  |
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| **PART J – CONTACT PERSON** | | |
| If further information or clarification of this document/position details please contact: | | |
|  |  |  |
|  | Name (please print) |  |
|  | Position |  |
|  | Contact telephone number |  |
|  | Email address |  |