**Placement and Supervisor**

**Approval**

**Purpose**

This form is to apply for a health service and/or supervisor to be approved for an International Medical Graduate (IMG) on the Specialist Pathway.

Doctors on a pathway to Fellowship are required to be in supervised placements that are approved as suitable for their program requirements and accredited against the relevant standards. IMG doctors must be in MM4-7 locations, with supervision meeting the Medical Board of Australia [Supervised practice guidelines](https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Supervised-practice-guidelines.aspx).

**Instructions**

Sections A and D must be completed in all applications.

Section B must be completed if the **health service is** **not** accredited for the ACRRM Fellowship Training Program.

Section C must be completed by FACRRM accredited for the ACRRM Fellowship Training Program.

Email the completed form to [img@acrrm.org.au](mailto:img@acrrm.org.au).

**Section A**

*Must be completed in all applications.*

**IMG details**

|  |  |
| --- | --- |
| Name |  |

**Health service details**

|  |  |
| --- | --- |
| Name of main facility/department |  |
| Postal address |  |
| Street address |  |
| Town/Suburb |  |
| State |  |
| Postcode |  |
| Telephone no |  |
| Modified Monash (MUST be MM 4 - 7) |  |
| Contact name |  |
| Contact position |  |
| Contact email |  |

## Placement details

|  |  |
| --- | --- |
| When did/will the doctor start working at this service? |  |
| Number of hours per week the doctor be working at this health service? |  |
| Detail any other services such as branch practices, hospital departments where the doctor will work. |  |

**Supervision details**

|  |  |
| --- | --- |
| Principal Supervisor name (FACRRM) |  |
| Additional Supervisor name (if applicable) |  |
| Supervision Level (MUST be Level 3 or 4) |  |
| What arrangements are in place if the supervisor is not available for a period? eg on holidays? |  |
| Does the supervisor work in the same service with the IMG most of the time? ☐ Yes ☐ No  If No, how often will the supervisor meet with the IMG?  Face to face       By phone or other virtual means  How will the IMG be supported in an emergency? | |

**Section B**

Must be c*ompleted if service is* ***NOT*** *accredited for the ACRRM Fellowship Training Program, check* [*accreditation status here*](https://mycollege.acrrm.org.au/search/find-teaching-post).

**Accreditations held**

Is the service accredited for any of the following?

|  |
| --- |
| General Practitioner Training - RACGP ☐ |
| John Flynn Placement Program – undergraduate ☐ |
| Community Integrated Clerkship – undergraduate ☐ |
| Junior Doctor General Practice Placement ☐ |
| Specialist College accreditations, please specify |
| RACGP Standards for General Practices ☐  If Yes, record dates of accreditation |
| ACHS Standards for Hospitals ☐  If Yes, record dates of accreditation |
| Other accreditations, please specify |

**Education activities to be offered to the IMG**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Offered | How often | Duration | Delivered by |
| Observation in practice & feedback | ☐ |  |  |  |
| Chart reviews | ☐ |  |  |  |
| Case presentations | ☐ |  |  |  |
| Topic presentations | ☐ |  |  |  |
| Journal Club | ☐ |  |  |  |
| Other | | | | |
| The IMG will have access to clinical resources while working ☐ Yes ☐ No | | | | |
| The IMG will be released for compulsory offsite education ☐ Yes ☐ No | | | | |
| Comments | | | | |

**Primary Care placement**

*Complete this page if the placement is based predominately in a primary care service. If based predominately in secondary care service move to next section.*

**Staffing at the primary health service**

|  |  |  |
| --- | --- | --- |
| **Role** | **Number** | **Total FTEs** |
| Doctor |  |  |
| Practice nurse |  |  |
| Practice manager |  |  |
| Receptionist |  |  |
| Allied health |  |  |
| Health worker |  |  |
| Will the IMG have a dedicated consultation room? | | ☐ Yes ☐ No |

**Patients seen per week**

|  |  |  |
| --- | --- | --- |
|  | **All doctors in health service** | **IMG** |
| In the practice |  |  |
| In nursing home |  |  |
| On a home visit |  |  |
| Other (specify) |  |  |

**Hours of work**

|  |  |  |
| --- | --- | --- |
|  | **Health service hours** | **IMG hours** |
| Mon-Fri |  |  |
| Saturday |  |  |
| Sunday |  |  |
| After hours Service |  |  |

**Clinical learning opportunities offered at this primary care service**

Please tick all boxes that apply

|  |
| --- |
| Care for an un-referred patient population ☐ |
| Care for undifferentiated acute and chronic health problems ☐ |
| Care for all age groups ☐ |
| Care for all genders ☐ |
| Care for Aboriginal and Torres Strait Islander people ☐ |
| Provision of continuity of care ☐ |
| Provision of preventative care activities ☐ |
| Provision of telehealth consultations ☐ |
| If you have **not** ticked each box above, describe the gaps |

**Hospital work**

|  |
| --- |
| Will the IMG work in the hospital? ☐ Yes ☐ No  If Yes, answer questions below |
| Hospital name |
| Will the IMG have VMO rights or admitting rights at a local hospital? ☐ Yes ☐ No  On average, how many patients will be cared for in the hospital each week? |
| Will the IMG take part in the emergency department roster? ☐ Yes ☐ No  If Yes, how often? |
| Will the IMG work in both primary care and the hospital ☐ Yes ☐ No  If Yes, number of hours per week, in primary care       at the hospital  Which hospital departments will the IMG work? |
| Will the supervisor accompany the IMG when they are working at the hospital? ☐ Yes ☐ No  If No, what supervision arrangements are in place when the IMG is working at the hospital? |

**Secondary Care placement**

*Complete this page if the placement is based predominately in a second care service.*

**Hospital profile**

|  |  |
| --- | --- |
| Number of acute beds |  |
| Number of Nursing Home beds |  |
| Services provided |  |
| Telehealth services provided? | ☐ Yes ☐ No |
| Is a Maternity Service available? | ☐ Yes ☐ No |
| Is there an Operating Theatre? | ☐ Yes ☐ No |
| Who provides the anaesthetics? ☐ Anesthetist | ☐ GP ☐ Anaesthetist |
| Who is the Accident and Emergency department staffed by? | ☐ MO ☐ VMO |
| Are there air retrievals from this hospital? | ☐ Yes ☐ No |
| What is the distance to the nearest base or teaching hospital? |  |
| What is the average travel time to the nearest base or teaching hospital? |  |

**Health services**

Indicate whether each of the following services is available locally, by referral or through a regular visiting health practitioner

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Local** | **Referral** | **Visiting Roster** |
| Aged Care Assessment | ☐ | ☐ | ☐ |
| Dermatologist | ☐ | ☐ | ☐ |
| Diabetes Educator | ☐ | ☐ | ☐ |
| Dietician | ☐ | ☐ | ☐ |
| General Surgeon | ☐ | ☐ | ☐ |
| Obstetrician | ☐ | ☐ | ☐ |
| Occupational Therapist | ☐ | ☐ | ☐ |
| Ophthalmologist | ☐ | ☐ | ☐ |
| Oncologist | ☐ | ☐ | ☐ |
| Orthopaedic Surgeon | ☐ | ☐ | ☐ |
| Paediatrician | ☐ | ☐ | ☐ |
| Pathologist | ☐ | ☐ | ☐ |
| Physician | ☐ | ☐ | ☐ |
| Physiotherapist | ☐ | ☐ | ☐ |
| Podiatrist | ☐ | ☐ | ☐ |
| Psychologists | ☐ | ☐ | ☐ |
| Radiologist | ☐ | ☐ | ☐ |
| Speech Therapist | ☐ | ☐ | ☐ |

**IMG hours of work**

|  |
| --- |
| Provide breakdown of time spent by the IMG:  Time working in the emergency department  Time working in other departments  List departments where doctor will be working |

**Section C**

*Must be completed by FACCRM supervisor accredited with ACRRM for the Fellowship Training Program.*

**Principal Supervisor**

Principal Supervisor who takes responsibility for the overall clinical and educational supervision must be FACRRM.

|  |  |
| --- | --- |
| Name |  |
| Address (if not at same service as IMG) |  |
| Email address |  |
| Phone number |  |
| AHPRA registration no |  |
| Does your medical registration have any imposed restrictions, conditions or limitations? ☐ Yes ☐ No | |
| Specialist Registration held ☐ General Practice ☐ Other Specialist, please specify | |
| Fellowship/s held ☐ FACRRM | |
| Are you up to date with the professional development requirements of your College? ☐ Yes ☐ No ☐ | |
| Are you already accredited to train registrars?  ACRRM registrars ☐ Yes ☐ No  RACGP registrars ☐ Yes ☐ No  If you answered yes, to either question, state which General Practice Training Organisation this is through:    Other College registrars ☐ Yes ☐ No | |
| How many other doctors without Specialist Registration are you supervising? | |

**Additional Supervisor**

Additional Supervisor who can assist with supervision (optional).

|  |  |
| --- | --- |
| Name |  |
| Address (if not at same service as IMG) |  |
| Email address |  |
| Phone number |  |
| AHPRA registration no |  |
| Does your medical registration have any imposed restrictions, conditions or limitations? ☐ Yes ☐ No | |
| Specialist Registration held ☐ General Practice ☐ Other Specialist, please specify | |
| Fellowship/s held ☐ FACRRM ☐ FRACGP ☐ Other College Fellowship, please specify | |
| Are you up to date with the professional development requirements of your College? ☐ Yes ☐ No ☐ | |
| Are you already accredited to train registrars?  ACRRM registrars ☐ Yes ☐ No  RACGP registrars ☐ Yes ☐ No  If you answered yes, to either question, state which General Practice Training Organisation this is through:  Other College registrars ☐ Yes ☐ No | |
| How many other doctors without Specialist Registration are you supervising? | |

**Section D**

*Must be completed in all applications.*

**Terms and Conditions**

The IMG has discussed this application with me, and I am aware of my responsibilities.

I accept responsibility for the overall clinical and educational supervision of the IMG experience in this service, which involves:

* ensuring that the service is suitably equipped with clinical equipment, clinical records systems, registers and office equipment to allow the doctor to practice safely
* ensuring that the doctor will have adequate access to diagnostic and medical services
* ensuring that the doctor will have an appropriate employment arrangement with the service
* ensuring that the supervisors, the service and the IMG are covered by appropriate insurance and medical registration
* ensuring that there is no conflict of interest between the supervisor and the IMG
* ensuring the service complies with Workplace Health and Safety regulations
* ensuring the service provides an orientation to the doctor
* ensuring the service has a policy available concerning responding to emergencies, work undertaken out of the service and after hours and the supervision of IMG in these situations
  + providing ACRRM with a Supervisor Report each three months
  + notifying ACRRM of any changes that may affect the service’s ability to support the IMG
  + notifying ACRRM of significant concerns about the IMG or any critical incidents involving the IMG.

**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 [here](http://www.acrrm.org.au/footer/privacy) in the [College's Privacy Policy](https://www.acrrm.org.au/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.

**Declaration**

☐ I agree to these terms and conditions

☐ I have read the Privacy Policy

☐ I declare this information to be true and accurate

*The form must be signed by the principal supervisor and the employer. The employer must be in a position of authority.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Principal supervisor** | Name | Date | Signature |
| **Employer** | Name  Position  Email | Date | Signature |

**College**

*To be completed by ACRRM.*

|  |  |
| --- | --- |
| Medical Educator | |
| ☐ Placement and Post Approved ☐ Placement and Post not supported | |
| ☐ Supervisor supported ☐ Supervisor not supported | |
| Name |  |
| Date |  |
| Notes |  |