

ACRRM Placement Confirmation Form

Purpose

This form is to confirm training placement information for registrars on the ACRRM Fellowship Pathway. Completed forms are to be emailed to ACRRM via your relevant regional training inbox.

training.nswact@acrrm.org.au

training.sa@acrrm.org.au

training.vic@acrrm.org.au

training.nt@acrrm.org.au

training.tas@acrrm.org.au

training.wa@acrrm.org.au

training.qld@acrrm.org.au

Placement/s will not be approved without a completed ACRRM Placement Confirmation Form.

Registrar Name:

Registrar Membership Number:

Training Information:

Which component of training do you plan to meet at this placement? ☐ AST ☐ CGT

Are you completing core hospital rotations at a Postgraduate Medical Council accredited hospital? ☐ Yes ☐ No

If yes, please include employment contact or letter of offer when submitting this form.

If Core Generalist Training (CGT), indicate the requirement/s you plan to meet below:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Rural and Remote | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Secondary Care | <input type="checkbox"/> Emergency Care |
| <input type="checkbox"/> Anaesthetics | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Obstetrics | |
-

If Advanced Specialised Training (AST), indicate the discipline below:

- | | | |
|---|---|--|
| <input type="checkbox"/> Aboriginal & Torres Strait Islander Health | <input type="checkbox"/> Academic Practice | <input type="checkbox"/> Adult Internal Medicine |
| <input type="checkbox"/> Anaesthetics | <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Obstetrics & Gynaecology | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Population Health | <input type="checkbox"/> Remote Medicine | <input type="checkbox"/> Surgery |
-

Placement Information:

Training Post Name:

Training Post Address:

Town/Suburb:

State:

Post Code:

Placement Start Date:**Placement End Date:****Registrar's Planned FTE:**

Supervisor Name:

Supervisor's Medicare Provider Number:

Is the supervisor working onsite at the training post?

☐ Yes☐ No

Please provide the supervisors planned FTE during the placement:

If this placement is an AST Academic Post, who is your Academic Supervisor?

Is your employment contract a single employment model (SEM)?

☐ Yes☐ No

Is the training post an Aboriginal Medical Service (AMS)?

☐ Yes☐ No*If yes, please submit a copy of the employment agreement with this form.**Eligible AMS training posts must provide the employment agreement to allow processing of salary support payments for registrars. Refer to [AGPT Salary Support Program Policy](#) for eligibility.*

Does your placement include Visiting Medical Officer rights (VMO)?

☐ Yes☐ No

Placement Branch/Associated Site/s:

Please list all additional sites you plan to work at during your placement, including either the FTE (full time equivalent) or the number of hours worked per week. Time at each additional site cannot be more than 0.4 FTE or 2 days per week based on a 38-hour training week (1 FTE in training).

Definitions:

Branch site: An additional site that is usually owned by the main site. The registrar would usually attend this site accompanied by their supervisor, for no more than two days per week. Under special circumstances, and with pre-approval, this can be pro-rated over a longer period of time.

Associated site: A location where the registrar may be required to work as part of their placement. This site is not owned or operated by the main site. Examples include a local rural hospital or nursing home. The registrar may attend this site for up to two days per week.

Examples:

1. Registrar works half a day at the hospital for 3 days per week. Their FTE per week at this site would be 0.3.
2. Registrar works 12 hours a week at second practice. This branch site would be 0.32 FTE per week.

Site Name	FTE/Hours	Supervisor
Example ACRRM Medical Centre	0.25	John Doe

Site Name	FTE	Supervisor

Placement Terms and Conditions

We confirm there is an employment agreement in place for this placement that meets the National Terms and Conditions of Employing Registrars, AMS agreement, and/or public health awards.

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[General Practice Registrars Australia – NTCER Guide](#)

[General Practice Supervisors Australia – NTCER Information](#)

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We confirm that the registrar holds no financial interest in the training post.

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We confirm that there is no conflict of interest between the supervisor and the registrar.

Privacy Agreement

We understand the Australian College of Rural and Remote Medicine ("the College") collects, stores and discloses our 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 us.

This information may be collected directly from us in our dealings with the College. To fulfill the purposes set out above, our 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 in the [College's Privacy Policy](#). 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☐

We declare the information in this form is true and accurate.

Please note:

Your placement/s will not count towards your training without the submission of this form prior to placement dates to generate placement approval, endorsement of Medicare Provider Number application/s, and initiation of eligible registrar, supervisor, or training post payments.

Registrar Name

Registrar Signature

Date

Training Post Representative Name:

Training Post Representative Signature

Date

Supervisor Name

Supervisor Signature

Date

ACRRM Internal Use Only

Medical educator or regional director of training approval

☐ Approved_____
Name_____
Role_____
Date**Comments**

If not approved, please provide details:

Regional Team Administration

Is the Core Hospital Rotations – PMC box ticked?

☐

Yes

☐

No

If so, was an employment agreement or letter of offer submitted with the form?

Has the registrar been approved for remote supervision?

☐

Yes

☐

No

Is the AMS Medical Services box ticked?

☐

Yes

☐

No

If so, was an employment agreement submitted with the form?

Regional delegate has reviewed placement confirmation form?

☐

Yes

☐

No

Comments