The Royal College of Pathologists of Australasia
ABN 52 000 173 231

Durham Hall 207 Albion Street Surry Hills NSW 2010 Australia
Telephone 61 2 8356 5858 Facsimile 61 2 8356 5828

RCPA
The Royal College of Pathologists of Australasia

APPLICATION FOR INITIAL REGISTRATION 2020
ESSENTIAL INFORMATION
FACULTY OF CLINICAL FORENSIC MEDICINE

CHECKLIST –
SUBMISSION OF DOCUMENTS:

Please check that the following documentary evidence is attached so that your initial registration with the College can be processed.

a) Medical registration ☐

b) Medical degrees and other qualifications ☐

c) Evidence of 3 years of clinical experience as an Intern or Resident Medical Officer ☐
The evidence will normally be a letter from the Medical Director or similar.

d) For Australian citizens/permanent residents whose basic primary medical qualification was not gained in Australia or New Zealand, proof of having passed the AMC assessment to work as a Doctor ☐ N/A ☐

e) Curriculum Vitae ☐

Certified copies of the original certificates must be presented. Please do not send originals as the College cannot be held responsible for the custody or return of documents. For OTS/AON, do not include previously submitted documents.

ACCREDITED SITE

Have you checked that your place of employment is an RCPA accredited site for training in Clinical Forensic Medicine and for the number of years you intend to work there? Trainees are responsible for ensuring the site is accredited by the College. ☐

PROSPECTIVE TRAINING PROGRAM

Your training program should be designed with your supervisor, outlining the content and form of your proposed training program during the year. The prospective training program must be submitted with your Initial Registration and then annually or on change of employment.

Prospective training program attached ☐

REQUEST FOR RETROSPECTIVE ACCREDITATION

If you wish to seek accreditation for training undertaken prior to the period of supervised training detailed on the Initial Registration form you must apply on the Retrospective Accreditation page of the form and submit supporting documentation, signed by the supervisor or Head of Department from the site in which the work was undertaken.

You may be required to pay a full or part fee to cover any period of retrospective accreditation.

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APPLICATION FOR INITIAL REGISTRATION – 2020

LAST NAME: _____

GIVEN NAMES: _____

HOME ADDRESS: _____

_____

_____ POSTCODE: _____

PREFERRED CONTACT ADDRESS: Home ☐ Work ☐

HOME PHONE: _____ MOBILE PHONE: _____

EMAIL: _____

GENDER: Male ☐ Female ☐ DATE OF BIRTH: _____/_____/_____
Day Month Year

NATIONALITY: _____

For Australian Trainees, are you: An Australian Citizen ☐ A permanent resident ☐

Other, please specify current VISA status _____

Are you of Aboriginal or Torres Strait Islander origin, or Māori descent?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Māori descent?

For persons of both Aboriginal and Torres Strait Islander origin, mark both "yes" boxes.

DATE COMMENCED TRAINING: _____/_____/_____
Day Month Year

GENERAL MEDICAL REGISTRATION:

Registration Number: _____ Country, State or Territory: _____

Date of Original Medical Registration: _____/_____/_____
Day Month Year

Medical Registration current to: _____/_____/_____
Day Month Year

DEGREES AND OTHER QUALIFICATIONS

DEGREE: _____ YEAR: _____ INSTITUTE: _____

DEGREE: _____ YEAR: _____ INSTITUTE: _____

DEGREE: _____ YEAR: _____ INSTITUTE: _____

OTHER (please specify): _____

FULL TIME ☐ PART TIME ☐ _____ hours / week

TRAINING IN YEAR OF COMMENCEMENT:

MAIN INSTITUTION*:* _____

IS THIS INSTITUTION: Public ☐ Private ☐

ADDRESS (Main): (Please specify your department and give the correct work address)

_____

_____

POSTCODE: _____ PHONE: _____

FAX: _____ EMAIL: _____

SUPERVISOR: _____
Title **First Name** **Last Name**

POSITION: _____ PHONE: _____

FAX: _____ EMAIL: _____

OTHER SITES ON ROTATION: _____

_____

_____

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PROSPECTIVE TRAINING OR RESEARCH PROGRAM

Please attach your Prospective Training or Research program for the year. The Program should be devised by the Supervisor in conjunction with the Trainee and should include the specific objectives for the year, taking into account any special needs (eg exam preparation, remediation or rotation for EPA exposure not provided by the site).

The Training program should include the items listed below. The program should be a concise summary of activities developed specifically for the applicant. It should be accompanied by a weekly or monthly timetable of activities.

1. **Brief overview of the site/service and its networks**

2. **Planned exposure to relevant experience:** EPAs to be addressed in the ensuing year; any rotations to other sites. If previous difficulties, what specific outcomes or achievements have been determined, eg. goals for the development of a specific skill set.

3. **Specific responsibilities relevant to level of skill and experience:** Eg: Entrustment levels achieved in various EPAs.

4. **Additional external experiences:** Eg: arrangements to receive specific EPA exposure in services which are not provided by the primary training site.

5. **Intended participation in projects or research**

6. **Educational program:** List regular activities, eg weekly journal club, departmental administrative or patient care meetings, as well as planned attendance at conferences or seminars.
   Please attach a weekly or monthly timetable of activities.

7. **Teaching and presentation activities:** Responsibilities for, eg. tutorials to medical students, conference papers and departmental presentations.

If you are unable to provide a Prospective Program, please state below the reason why and advise when it will be provided. If this program is not received by the end of the current year the College may not be able to accredit that year of training.

SUPERVISION

This is to confirm that I, _____, have agreed to act as Supervisor
(Please print full name)

for the period from _____/_____/_____ to _____/_____/_____
Day Month Year Day Month Year

I am prepared to fulfil the responsibilities laid down by the College.
For further information, please refer to the following link: *Training-with-the-RCPA*

I have developed the attached Prospective Training Program with the Trainee.

Signature of Supervisor: _____ Date: _____

Trainee Signature: _____ Date: _____

PRIVACY AND CONFIDENTIALITY

Any personal information you provide is strictly confidential to the College. However, in the course of your training it may be necessary for the College to provide your contact details and information about your progress or examination performance to College committees and Fellows of the College who are involved with supervision and training. If the personal information is not provided to the College, the College may be unable to process your application, or to review and assess your training progress and examination performance. The College will manage your personal information in accordance with its Privacy Policy. If you would like to access any information we hold about you or obtain a copy of our Privacy Policy please contact our Privacy Officer on + 61 2 8356 5858.

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APPLICATION FOR RETROSPECTIVE ACCREDITATION OF TRAINING TIME

Application for retrospective accreditation must be made at the time of Initial Registration, with full supporting documentation (eg training programs, supervisors' reports and letters outlining the relevance for clinical forensic medicine training). If you do not apply now then retrospective accreditation may not be granted at a later date. You will be advised of the result and any payment required once approved by the relevant Chief Examiner.

Training Institution: _____

Dates: _____

Total Duration (months) _____

Documents Attached: _____

Training Institution: _____

Dates: _____

Total Duration: _____

Documents Attached: _____

Please send in the completed forms by post.

Postal Address:

BEA – Board of Education and Assessment Office
The Royal College of Pathologists Australasia
207 Albion Street
Surry Hills NSW 2010
Australia

Please ensure you have completed all relevant information required, incomplete applications will not be processed. Faxed applications will not be accepted.

Office Use Only: *Payment correct* ☐ *$* _____

Cheque ☐ *Money Order* ☐ *Current Credit Card* ☐
Laboratory accredited ☐ *Member ID created:* _____

Administrator: _____ *Entered* ☐

Current medical registration ☐ *Qualifications* ☐
Clinical experience ☐ *Prospective Training Program* ☐
Retrospective approved ☐ *Retrospective to Chief Examiner* ☐

Registrar: _____ *Date:* _____