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| Subspecialty Training ProgramsProspective Approval 2024Form B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| --- | --- |
| **Trainee Details** | RANZCOG ID Number |
| Last Name | First Name |
| Date of Birth | Male □ Female □ Indeterminate/intersex/unspecified □ |
| Please tick box applicable to you -In 2024 I will be training towards □ FRANZCOG & Subspecialty Certification or □ Subspecialty Certification |

|  |
| --- |
| I will be training in 2024 in the following Subspecialty Training Program *(please tick)* □ CGO □ CMFM □ COGU □ CREI □ CU***Year 1*** *of clinical training may be completed either as part time (minimum 0.5FTE) or full time. Training must be spent in a prospectively approved RANZCOG Subspecialty accredited training unit.*Year of Training □ Year 1 □ Year 2 □ Year 3 □ Full time □ Part time Hours per week …………. FTE …………. (*0.5 – 1.0 e.g.0.6)*Training Period from to   |
| Name of Subspecialty accredited training unit for this accredited training positionName of Training SupervisorCurrent Training Unit *(compete if you are currently in a Subspecialty Training Program)*Number of years/months: |

## Prospective Approval

Trainees must submit their application for prospective approval of training not less than eight weeks prior to the commencement of training in each year of training, to the relevant Subspecialty email address:
cgo@ranzcog.edu.au, cmfm@ranzcog.edu.au, cogu@ranzcog.edu.au, crei@ranzcog.edu.au, cu@ranzcog.edu.au.

## Payment of Fees

All trainees regardless of whether training full or part time, must pay their annual training fee to RANZCOG by 31 January of each year. Trainees who have not paid their fees by 31 January will incur a late fee for each month they are overdue.

## Details of Training (attached additional sheets if necessary)

Objectives and Description of Training to be undertaken this year

Skills to be developed, type of training to be undertaken e.g. training in a special training unit, studying in a course

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## Location of Training

Please list all units at which you will be undertaking training indicating whether public/private

e.g. hospital, clinic, consulting rooms, tertiary institution etc

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## Advanced or Essential Training Modules (for trainees who commenced FRANZCOG training from 1 December 2014)

If you have yet to complete your compulsory Advanced or Essential Training Modules (ATMs or ETMs), please outline your plans to meet this FRANZCOG requirement over the next 12 months of training. Please include information on how your hospital will assist you during your training. For more information on the ATMs & ETMs please contact training@ranzcog.edu.au

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## Gynaecological Oncology Fortnightly Timetable ONLY (delete if not applicable)

Trainee Name:……………………………… Training Unit: ……………………………… Year of Training 1 / 2 / 3

Trainees are required to complete a FORTNIGHTLY timetable for Week 1 **AND** Week 2.

If Week 2 is the same as Week 1, please indicate this in the box provided on the following page.

If there was a significant change in the Training Program during the training period, please notify CGO Coordinator and submit a revised timetable for the period.

*PLEASE NOTE Tick only one box in the Activity section to indicate the principle activity intended for that session*

**WEEK 1**

Number of Ward Rounds Per Week

|  |  |  |
| --- | --- | --- |
| **DAY** | **MORNING** | **AFTERNOON** |
| **MONDAY** | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| **TUESDAY** | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| **WEDNESDAY** | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| **THURSDAY** | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| **FRIDAY** | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |

## Statement from Clinical Director of Obstetrics and Gynaecology

I confirm that the above proposed timetable accurately reflects the subspecialty training activities for Dr
during each week of training in the subspecialty for the time fraction and period specified on page 1 of this form.

Print Name: ………………………………………………………… Signature ……………………………………………………………

 Director of Obstetrics and Gynaecology

Date ……………………………………………………………….

## Gynaecological Oncology Fortnightly Timetable ONLY (delete if not applicable)

WEEK 2

* **Tick if Week 2 same as Week 1**

|  |  |  |
| --- | --- | --- |
| DAY | MORNING | AFTERNOON |
| MONDAY | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| TUESDAY | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| WEDNESDAY | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| THURSDAY | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |
| FRIDAY | SITE | SITE |
| ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 | ACTIVITY* Primary surgeon
* Outpatient Oncology
* Admin/Education/Ward meeting
* Tumour Conference
 | * Primary assistant
* Outpatient Colposcopy
* Research
* No activity
 |
| CONSULTANT SUPERVISING | CONSULTANT SUPERVISING |

Details of On Call / After Hours

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## Statement from Clinical Director of Obstetrics and Gynaecology

I confirm that the above proposed timetable accurately reflects the subspecialty training activities for Dr
during each week of training in the subspecialty for the time fraction and period specified on page 1 of this form.

Date ……………………………………………………………….

Print Name: ………………………………………………………… Signature ……………………………………………………………

 Director of Obstetrics and Gynaecology

## CMFM Fortnightly Timetable ONLY (delete if not applicable)

Trainees are required to complete a FORTNIGHTLY timetable for Week 1 **AND** Week 2.

If Week 2 is the same as Week 1, please indicate this in the box provided on the following page.

*PLEASE NOTE Tick only one box in the Activity section to indicate the principle activity intended for that session*

Trainees are required to complete a WEEKLY timetable for each week of training should there be a 2 or 4 week cycle

**Week 1**

|  |  |  |
| --- | --- | --- |
| DAY | **MORNING** | **AFTERNOON** |
| MONDAY | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  |
|  |
| TUESDAY | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 |  | Preterm Birth Diabetes Clinic Scholarly Elective AdminClinic Other |
|  |
| WEDNESDAY | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |
|  |
| THURSDAY | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other

\_ |
|  |  |  |
| FRIDAY | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |

Details of On Call / After Hours

|  |
| --- |
|  |

## CMFM Fortnightly Timetable ONLY (delete if not applicable)

* **Tick if Week 2 is the same as Week 1**

|  |  |  |
| --- | --- | --- |
| **DAY** | **MORNING** | **AFTERNOON** |
| **MONDAY** | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  |
|  |
| **TUESDAY** | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 |  | Preterm Birth Diabetes Clinic Scholarly Elective AdminClinic Other |
|  |
| **WEDNESDAY** | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |
|  |
| **THURSDAY** | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other \_
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |  | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other

\_ |
|  |  |  |
| **FRIDAY** | CONSULTANT SUPERVISING | SITE | CONSULTANT SUPERVISING | SITE |
| ACTIVITY | ACTIVITY |
| * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 | * Maternal Medical Clinic
* Fetal Medicine Clinic
* Ultrasound Scanning List
* Caesarian List
* Labour Ward Cover
* Other
 | * Preterm Birth
* Diabetes Clinic
* Scholarly Elective
* Admin
* Clinic Other
 |

Details of On Call / After Hours

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|  |

## Statement from Clinical Director of Obstetrics and Gynaecology

I confirm that the above proposed timetable(s) accurately reflect(s) the Subspecialty training activities for Dr……………………..
during each week of training in the CMFM Subspecialty for the time fraction and period specified on page 1 of this form.

Date ……………………………………………………………….

Print Name: ………………………………………………………… Signature ……………………………………………………………

 Director of Obstetrics and Gynaecology

## COGU – CREI – CU Weekly Timetable

## (delete if not applicable)

The Weekly Timetable is for recording your weekly timetable activities. Please include the activity, site and consultant supervising each of the 10 sessions undertaken each week / fortnight / month.

For each activity you MUST indicate whether the site is Public or Private

Trainees are required to complete a WEEKLY timetable for each week of training should there be a 2 or 4 week cycle

|  |  |  |
| --- | --- | --- |
| Day of Week | Morning | Afternoon |
| MONDAY | A | A |
| U/S | U/S |
| CS | CS |
| TUESDAY | A | A |
| U/S | U/S |
| CS | CS |
| WEDNESDAY | A | A |
| U/S | U/S |
| CS | CS |
| THURSDAY | A | A |
| U/S | U/S |
| CS | CS |
| FRIDAY | A | A |
| U/S | U/S |
| CS | CS |

 A = Activity U/S = Unit / Site CS = Consultant Supervising

Details of On Call / After Hours

|  |
| --- |
|  |

## Statement from Clinical Director of Obstetrics and Gynaecology

I confirm that the above proposed timetable accurately reflects the subspecialty training activities for Dr during each week of training in the subspecialty for the time fraction and period specified on page 1 of this form.

Print Name: ………………………………………………………… Signature ……………………………………………………………

 Director of Obstetrics and Gynaecology

 Date ……………………………………………………………….

## Training Plan for 2024

*Please provide a short description of your objectives for the following periods*

Semester 1

*Please indicate period of training*

|  |
| --- |
|  |

Semester 2

*Please indicate period of training*

|  |
| --- |
|  |

## Statement from the Principal Training Supervisor

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am willing to act as the Principal Training Supervisor for the above-mentioned trainee.
I have read the training proposal of the trainee and can confirm the nature of the training to be undertaken and the role of the trainee.

I understand that as the Training Supervisor of a trainee completing a period of training

* I must complete a compulsory Formative Appraisal Report (FAR) for the trainee, at three and nine months of training and meet with him / her to discuss and sign the report, and
* I must complete a compulsory Training Assessment Record (TAR) including the six-monthly summative assessment report, for the trainee, at six and twelve months of training, and meet with him / her to discuss and sign the report.

Training Supervisor Signature …………………………………………………………………….. Date …………………………………

|  |
| --- |
| The following documentation must be submitted with this form *(please tick each box)*□ 2024 Registration Form (Form A)□ Hospital Letter of Employment / Training Unit confirming appointment *(and fractional training (FTE) if relevant)*□ Copy of current Medical Board of Australia or MCNZ APC *(NZ only)* Registration |

|  |
| --- |
| Declaration |
| I understand that:* Approval of training is conditional on fee payment. Payment of the annual training fee be made by 31 January
* I am applying for prospective approval of training to be undertaken at the above-named accredited training unit and listed accredited sites and acknowledge that my registration is conditional upon obtaining prospective approval.
* If any of the above information changes during my training year, it is my responsibility to notify the College immediately and obtain prospective approval from the relevant Subspecialty Committee accordingly.
* I understand that if I submit this form after commencement of the above specified subspecialty training, no period of training undertaken prior to submission and receipt of the document will be credited.

Trainee Signature …………………………………………………………………….. Date ………………………………… |

|  |
| --- |
| Approval by Chair of Relevant SubspecialtyBased on information provided in this form the proposed training is □ Approved □ Not ApprovedName ………………………………………………………………………Signature …………………………………………………………………….. Date …………………………………Comment ………………………    |