SOMANZ
SOCIETY OF OBSTETRIC MEDICINE OF AUSTRALIA AND NEW ZEALAND

SOMANZ Training Committee

Application for Prospective Approval of Obstetric Medicine Training for Fellows

Important Information

This application form is for use by Fellows who intend to undertake post fellowship training in Obstetric Medicine with the intent to receive the Obstetric Medicine certificate from SOMANZ

You are advised to retain a copy of the completed form for your records.

Before you complete this form – Please ensure you have read and familiarised yourself with the relevant requirements for Obstetric Medicine training.
Applications can span multiple training years but may not exceed 12 months per application.

Closing Dates

Australia	**New Zealand**
15 February for approval of the first half or the entire training year **31 August** for approval of the second half of the training year	**31 October** for approval of the first half or the entire training year **31 March** for approval of Apr-Aug rotations **31 May** for approval of the second half of the training year

Notification of Approval

Once your application has been considered by the SOMANZ training committee, you will be notified of the decision in writing. Whenever possible, this advice will be sent *within six weeks* of the application deadline. The committee will approve the application, decline the application or defer the decision pending provision of further information.

Applications submitted after the published deadlines will attract a late fee. Consideration of applications submitted after the deadline may be delayed. Late applications will not be accepted from one month after the published deadline. If your application is submitted late, you must attach a letter requesting consideration of exceptional circumstances outlining the reasons for the delay.

Payment of Training Fees

You will be invoiced for your training **once your training has been approved**.

The current schedule of training fees:

6 months training $150

12 months training $300

Late fee $50

Enquiries & Application Submission

Australian Office
SOMANZ Secretariat **Postal Address: 145 Macquarie Street, Sydney NSW 2000** **Deliveries: Level 1, 149 Macquarie Street, Sydney NSW 2000** **E admin@somanz.org**

Please ensure you have saved a copy of your application for your records and email an electronically saved or clearly scanned copy to the email above (photos will not be accepted). Please CC in your nominated supervisors for their records also.

Emailed applications will be accepted

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This application may cover a single term/rotation or more than one term/rotation occurring in the year.

1. PERSONAL DETAILS

Full Name of Trainee		
	SURNAME / FAMILY NAME	GIVEN / FIRST NAME(S)
Contact E-mail		
	NB: SOMANZ will use email as the primary method to communicate with you throughout your Training.	

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

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

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

Māori iwi affiliation

2. TRAINEE DETAILS

Division: Adult Medicine
Region: (Country where you completed Advanced Training) ☐ Australia ☐ New Zealand

RACP Fellowship Year Obtained:

Specailty/Specialties:

Obstetric Medicine Training Status – New trainee ☐

Continuing trainee ☐

3. DETAILS OF PROPOSED OBSTETRIC MEDICINE TRAINING PROGRAM

Number of terms/runs indicated on this application:

If you are in one position for the whole period of training indicated on this application form, please provide further details under Term 1 only.

Appointment in:

%	%	%	%	%
Public Hospital	Private Hospital	Private Facilities In Public Hospital	Private Out-Patient Clinics Within Public Hospital	Other (please indicate):

TERM No. 1

☐ Full time or ☐ Part time

If part time, percentage of full time training: %

Duration of this training term (months):

Commencing:

Ending:

dd/mm/yy

Post or position:	
Hospital/Institution:	
Address:	

Please provide a weekly timetable for your position(s), outlining what you are doing each day.

TERM No. 1

	Monday	Tuesday	Wednesday	Thursday	Friday
am					
pm					

Inpatient Activity:

Number of inpatients per week	
Number of Consultant led ward rounds	
Number of Registrar led ward rounds	

Describe the nature and content of your inpatient work: e.g. Acuity of patients

Multi-disciplinary Care:

Describe the members of and your role within the multi-disciplinary team:

Describe your **Administrative Responsibilities**:

Describe any responsibilities at associated centres / peripheral hospitals:

Describe your **supervisory responsibilities**:

TERM No. 2 (if applicable)

☐ Full time or ☐ Part time If part time, percentage of full time training: %

Duration of this training term (months): Commencing: dd/mm/yy Ending: dd/mm/yy

Post or position:	
Hospital/Institution:	
Address:	

Please provide a weekly timetable for your position(s), outlining what you are doing each day.

TERM No. 2 (if applicable)

	Monday	Tuesday	Wednesday	Thursday	Friday
am					
pm					

Inpatient Activity:

Number of inpatients per week	
Number of Consultant led ward rounds	
Number of Registrar led ward rounds	

Describe the nature and content of your inpatient work: e.g. Acuity of patients

Multi-disciplinary Care:

Describe the members of and your role within the multi-disciplinary team:

Describe your **Administrative Responsibilities**:

Describe any responsibilities at associated centres / peripheral hospitals:

Describe your **supervisory responsibilities**:

4. SUPERVISOR(S)

It is mandatory that you have <u>two</u> supervisors for the period(s) of training indicated on this application form. At least 1 supervisor needs to be recognised as an Obstetric Medicine Physician by SOMANZ

Both supervisors can submit composite Supervisor's Reports, although if their feedback differs, separate reports should be submitted. ***Please note, both you and your supervisors must sign this application before it is submitted to the SOMANZ Training Committee.***

Supervisor 1

Full Name of Supervisor:			
Qualification(s):			
Full Address:			
Phone: (W)		Fax: (W)	
E-mail:			

Please specify the period of supervision: Commencing _____ (dd/mm/yy) Ending: _____ (dd/mm/yy)

☐ I (supervisor) have sighted the supervisors' reports from previous training periods and other documentation relevant to the trainee's progression (if applicable) for this trainee and identified any ongoing issues for inclusion in the trainee's learning plan for this period.

Supervisor's Signature: _____ Date: _____

Supervisor 2

Full Name of Supervisor:			
Qualification(s):			
Full Address:			
Phone: (W)		Fax: (W)	
E-mail:			

Please specify the period of supervision: Commencing _____ (dd/mm/yy) Ending: _____ (dd/mm/yy)

☐ I (supervisor) have sighted the supervisors' reports from previous training periods and other documentation relevant to the trainee's progression (if applicable) for this trainee and identified any ongoing issues for inclusion in the trainee's learning plan for this period.

Supervisor's Signature:		Date:	

Supervisor 3 ***(if applicable)***

Full Name of Supervisor:			
Qualification(s):			
Full Address:			
Phone: (W)		Fax: (W)	
E-mail:			

Please specify the period of supervision: Commencing _____ (dd/mm/yy) Ending: _____ (dd/mm/yy)

☐ I (supervisor) have sighted the supervisors' reports from previous training periods and other documentation relevant to the trainee's progression (if applicable) for this trainee and identified any ongoing issues for inclusion in the trainee's learning plan for this period.

Supervisor's Signature:		Date:	

5. OTHER TRAINING ACTIVITIES

Details of educational activity available 'in house' e.g. grand rounds, peer review sessions, journal club etc.

Details of conferences you plan to attend/have attended

Teaching

Indicate hours per week to be spent in teaching

Undergraduates		Intern/RMOS		Basic trainees		Nursing staff	

Publication and Research (as part of clinical year)

Indicate hours per week to be given to research

Document research activities:

Intended presentations

Intended publications

Project Topic

Please describe the project that you plan to undertake in consultation with your supervisor. Please refer to the Obstetric Medicine training page for information and guidance concerning preparation and submission of project reports.

6. BRIEF OUTLINE OF OBSTETRIC MEDICINE TRAINING ALREADY UNDERTAKEN

7. BRIEF OUTLINE OF OBSTETRIC MEDICINE TRAINING INTENDED SUBSEQUENT TO THIS YEAR

8. TRAINEE DECLARATION *(please tick boxes that apply)*

☐ I declare the information supplied on this form is complete and accurate

☐ I have provided my supervisor(s) with copies of supervisors' reports from previous training periods and other documentation relevant to my progression

☐ I have liaised with my supervisor to confirm that the position outlined within this application is in line with the current accreditation granted for this setting and/or, where accreditation of the setting is not required, meets the standards for training.

☐ My supervisors have confirmed the training information included in this application and have signed this form.

Trainee's Signature: Date:

Please ensure you make a copy of the completed application form for your personal records and send the original to SOMANZ by the due date.