



Clinical Attachments Grant Application Form*

Personal Details

Name: _____

Practice Address: _____

_____ Postcode: _____

Telephone: () _____ Fax: () _____

Email Address: _____

Professional Details

ACRRM Number _____ RACGP Number _____

Primary Medical Degree

University of Graduation _____ Year _____

Current practice type *(please tick)*

Solo Group Practice RFDS AMS/ACCHS Qld Health Salaried

Other *(please specify)* _____

Are you Full Time? Or Part Time? _____ hrs/week

Are you a member of your local Division of General Practice? Yes No

Number of years in General Practice in Australia _____

Number of years in Rural General Practice (RRMA 7-4) in Australia _____

How many other doctors in your town (excluding yourself) _____

Are you currently enrolled in:

The Australian General Practice Vocational Training Program? Yes No

The Rural Locum Relief Program? Yes No

Doctors for the Bush? Yes No

Specify any additional qualifications or postgraduate training already undertaken relevant to rural general practice? (please tick where appropriate and specify year)

Emergency Management of Severe Trauma (EMST) Year _____

Emergency Life Support (ELS) Year _____

Advanced Paediatric Life Support (APLS) Year _____

* Please note that GP Proceduralists are not eligible for Health Workforce Queensland Clinical Attachment Grants

Professional Details cont-

Additional qualifications or postgraduate training continued –

Rural Anaesthetic Crisis Resource Management Year _____

Rural Emergency Crisis Resource Management Year _____

Advanced Life Support Obstetrics (ALSO) Year _____

Advanced Certificate in Women’s Health Year _____

Diploma in Obstetrics Year _____

Diploma in Anaesthetics Year _____

Diploma in Child Health Year _____

Grad Diploma in Rural General Practice Year _____

Other (Please Specify) _____ Year _____

Are you a proceduralist eligible for the Medicare Plus Training Grant in Obstetrics, Anesthetics or Surgery? *

Yes No **If yes, will you be accessing the grant for your clinical attachment?**

Please include a copy of your current medical indemnity coverage with your application

Clinical Attachment Details

Type of Clinical Attachment Requested? _____

Preferred location of Clinical Attachment? (Name three) _____

Dates of Clinical Attachment Preferred? _____

Total Number of Days of Training (FTE) _____

Total Numbers of Hours _____

Have you obtained funding or assistance from any other source to undertake this clinical attachment?

Yes No **If yes, what assistance is being received?** _____

Clinical Attachment Details cont-

Why do you wish to undertake this clinical attachment?

What are the particular health needs in your local community for which you require this training and how did you identify them?

How will this training enable you to meet these needs?

Would you like your clinical attachment accredited CPD/PDP points through RACGP or ACRRM?

Yes No

Learning Objectives: Please name three specific skills or areas of knowledge you wish to improve or learn during the clinical attachment

1.

2.

3.

What do you plan to use these skills or areas of knowledge for after completing the clinical attachment?

Clinical Attachment Details cont-

How would you like your clinical attachment to be structured? (e.g. daily weekly, teaching sessions, case conferencing etc) Describe your desired clinical attachment experience.

I _____ verify that all the information I have given on this application is true and correct. I have also enclosed a copy of my current medical indemnity coverage.

Signature _____ Date _____

PLEASE FAX FORM TO 07 3105 7801
OR
MAIL TO HEALTH WORKFORCE QUEENSLAND PO BOX 2523 BRISBANE QLD 4001