MDRAP SUPERVISION PLAN

WITHOUT GP EXPERIENCE/JUNIOR DOCTOR CATEGORY ONLY, OR AS DIRECTED

This form is to be completed by the participant and their approved supervisors to assess the suitability for the participant to continue in the program and to adjust the level of supervision.

This form is to be completed:

+ By applicants in the Without GP Experience/Junior Doctor Category
+ At time of MDRAP application
+ At any other time if requested or considered necessary by the Supervisors or Health Workforce Queensland

COMPLETING THIS FORM

- Read and complete all required questions
- Read the *Privacy Notice* on the last page
- Type or print clearly in **BLOCK LETTERS**
- Place **X** in all applicable boxes
- Ensure that all pages and required attachments are returned to mdrap@healthworkforce.com.au

INSTRUCTIONS FOR THE PARTICIPANT DOCTOR

- You should complete this form first. This enables you to identify your strengths and areas for further improvement.
- Once completed, give the form to your supervisor to complete. You must discuss this review with your approved principal supervisor and co-supervisors. At the end of the feedback session, sign the form before sending it to Health Workforce Queensland

INSTRUCTIONS FOR THE PRINCIPAL SUPERVISOR

- Consider input from co-supervisors of the participant to ensure that a thorough and accurate assessment is made. .
- Both you and the participant must sign the form where required and the form must be sent to Health Workforce Queensland.
- Where the day-to-day supervision will be delegated to term co-supervisors, this Supervision Plan can be completed by the term co-supervisor(s).

SECTION A

APPLICANT DETAILS

Full Name : .....

DETAILS OF PROPOSED EMPLOYER)

Practice Contact : .....

Name of Practice : .....

Address : .....

Contact Number : .....

Proposed Role : .....

DESCRIPTION OF EMPLOYMENT

Include hours of work, on-call commitment, employee/contractor etc.:

SECTION B

DETAILS OF YOUR PROFESSIONAL DEVELOPMENT PLAN

Learning needs analysis

You should consider the knowledge and skills that are required for the proposed position in order to determine any gaps in your knowledge and skills. You should then develop a program to address your learning needs.

List any gaps in knowledge and skills and provide the measures to address these. For example, list any professional development, training or programs to be completed. Include goals to be achieved and expected outcomes and timeframes for achievement of goals.

Learning needs	How you will address these learning needs

PROFESSIONAL DEVELOPMENT ACTIVITIES

List any professional development activities you have undertaken in the 12 months prior to the submission of your plan

SUPERVISION AND FEEDBACK

It is expected that you will be provided with the adequate support and supervision to enable you to practise safely.

Detail the following (attach additional pages if more space is required)

Name and position of supervisor

Describe the proposed orientation to the workplace

Describe how supervision will be provided (e.g. direct, on-site, telephone)
Supervision must incorporate MDRAP requirements as below:
***Applicants in this category must complete the First Month in approved placement at equivalent AHPRA Level 1**

How will the practitioner's performance be monitored and reviewed? (e.g. logbooks, record reviews, audit, multi-source feedback)

What is the anticipated date for completion of the proposed plan?

What measures will be put in place if the learning needs are not satisfactorily met within the anticipated time frame, or are there any concerns about safety to practice?

SECTION C

PRACTITIONER AND SUPERVISOR AGREEMENT

Practitioner Statement

I agree to abide by the supervision plan that has been approved by my supervisor under the MDRAP.
I agree that I am responsible for my own professional development and learning needs. I will work within my level of competence and will seek assistance when necessary. I will undertake professional development activities to enable me to overcome any deficiencies in my professional knowledge or skills.

I give permission for my supervisor to contact the Medical Board if he or she has concerns about my professional performance.

Applicant Name : .....

Applicant Signature : ..... **Date:** .....

Supervisor Statement

I agree to undertake the supervisory and support role outlined in this supervision plan.

I will notify the Medical Board and Health Workforce Queensland if I am concerned that the professional performance of this doctor is placing the public at risk and if I cannot provide the necessary support to ensure the safety of the public.

Supervisor Name : ..... **Registration Number:** .....

Supervisor Signature : ..... **Date:** .....

If required, Co-Supervisor Signature

Co-Supervisor Name : ..... **Registration Number:** .....

Co-Supervisor Signature : ..... **Date:** .....

PRIVACY NOTICE

Health Workforce Queensland and the network of Rural Workforce Agencies are committed to protecting your personal information in accordance with the *Privacy Act 1988 (Cth)*. The personal information (that is, information that identifies you) collected in this form is required so that Health Workforce Queensland can confirm that the MDRAP Supervision Plan is satisfactory. If you do not provide the required information, it may not be possible for the proposed supervised practice plan to proceed.

By signing this form, you confirm that:

- You have read and understand the Privacy Notice above
- All information provided is true and correct.

Name of MDRAP Member : .....

Signature : ..... **Date:** .....

Name of Principal Supervisor : .....

Signature : ..... **Date:** .....

If required, Co-Supervisor Signature

Name of first Co-Supervisor : .....

Signature : ..... **Date:** .....