FPM
FACULTY OF PAIN MEDICINE
ANZCA

ABN 82 055 042 852

2019 Application for FPM Training

The Faculty of Pain Medicine training program is open to applicants who hold a primary specialist qualification acceptable to the board or who have completed at least three years full-time equivalent training within that primary specialty.

1. Personal Information

College ID (*if applicable)*: ___ / ___ / ___ / ___ / ___

Surname: _____ First Name: _____

Middle Name: _____ Preferred Name:_____ Gender: M / F
If different from first name

Previous or Maiden Name: : _____ Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

2. Personal details

Please tick preferred address

☐ **Home Address:** _____

Suburb:_____ State: _____

Postcode: _____ Country:_____

☐ **Work Address**: _____

Suburb:_____ State: _____

Postcode: _____ Country:_____

3. Phone Numbers

Home: _____ Mobile: _____

Work: _____ Fax: _____

4. Email Addresses

Primary: _____

Secondary:_____

5. Indigenous Status

FPM ANZCA, in association with the Council of Presidents of the Medical Colleges, collects workforce data to ascertain the numbers of Indigenous Fellows and trainees working in Australia and New Zealand. The following question is voluntary.

Do you identify as any of the following: if so, please select one or more categories as appropriate.

☐ Aboriginal ☐ Torres Strait Islander ☐ Maori ☐ Pacific Islander

6. Qualifying Medical Degree

Name on Degree: _____

Degree Title:_____

University: _____

Country: _____

Date of Graduation: __ __ / __ __ / __ __ __ __

Attach a Passport- Size Photo here
Width: 35-40mm
Height: 45-50mm

Please sign within limits of the box

7. Medical Registration

Please provide the a certified copy of your current medical registration.
Trainees are required to notify the faculty should registration conditions change.

Registration Number: _____

Country: _____

8. Primary Specialist Qualification

Fellowship of the Faculty of Pain Medicine is a post fellowship specialist qualification contingent upon the trainee holding a primary specialist qualification acceptable to the Board. Confirm below if you are a current Trainee or Fellow of the following:

Primary Specialist Qualification	Fellow	Trainee
ANZCA		
RACS		
AFRM (RACP)		
RACP		
RANZCP		
Other		

Primary Specialist Qualification	Fellow	Trainee
RACGP		
ACRRM		
CICM		
RANZCOG		
ACEM		

If other please specify:_____

If you are currently undertaking training towards your primary speciality, please confirm how many years of training you have undertaken _____

(Trainees may enter pain medicine training prior to gaining fellowship in their primary specialty, but should have completed at least 3 years FTE within the primary specialty).

How many years are still required before you complete your training towards your primary specialty training?____

9. Training Unit Placement(s)

The trainee providing this application has been accepted into a pain unit accredited for training for Fellowship of the Faculty of Pain Medicine, ANZCA.

Training Unit	State/Country	Full/Part-Time (Indicate FTE)	From DD/MM/YY	To DD/MM/YY

10. Verification from Supervisor of Training of Pain Unit

In order to achieve registration, the Supervisor of Training (SoT) of the pain unit must formally verify that a trainee is in a post which complies with all the requirements of training FPM trainees. These requirements include, but are not necessarily limited to, appropriate levels of supervision, a suitable mix of cases, all the required FPM assessment processes, and comprehensive access to all the relevant education, teaching and quality assurance programs within the department.

I can confirm Dr_____ will be working in a post which complies with all the requirements for training FPM trainees.

Name of SoT: _____ Signature: _____ Date: _____

11. Declaration of Applicant

DECLARATION OF APPLICANT

I declare that the statements made in this application are true and accurate and agree to the following:

1. I understand that FPM collects and holds personal data for the purpose of trainee enrolment and for the administering of the training program. I consent to having this information used for these purposes and as authorised in the ANZCA privacy policy. If I wish at any time to request access to the information I have provided, I understand that I may contact FPM and request to view it.
2. I certify that I have no illness or disability that would preclude the safe practice of pain medicine, including dependence on or inappropriate use of alcohol or recreational and/or non-prescribed drugs, and/or treatment with prescribed drugs likely to compromise my practice. I acknowledge that if I develop any dependence on recreation or non-prescribed drugs, or any condition that precludes the safe practice of pain medicine, this may result in the suspension or termination of my application.
3. I undertake to notify the Faculty if my medical registration is withdrawn or suspended , or conditions are placed on my medical registration, or if I receive notice of any complaint to any medical registration authority.
4. I understand that email will be primary means by which communication is maintained between me and the Faculty and that the Faculty will use the email address I designate as my primary email. I undertake to regularly access the designated primary email account.
5. I understand that processing an application does not guarantee entry into the training program, nor employment by an accredited training unit.

Signature of applicant: _____ Date: _____

12. Fees - Payment Details

The trainee application fee is a non-refundable fee that covers access to applicant resources including the Better Pain Management modules. An annual training fee will be charged prior to the commencement of each year of training.

2019 Application Fees *(please tick one)*			
Australia	☐ AUD $2545.00 (includes 10% GST)	**New Zealand**	☐ NZD $2920.00 (includes 15% GST)

Payment Methods

☐ **Cheque**. Bank Draft or Money Order attached
(Payable to ANZCA and crossed "Not Negotiable". If you are paying by cheque in New Zealand, please send completed form to NZ National Office.)

☐ **Credit Card** (please tick one) ☐ VISA ☐ MasterCard

Credit card number

Expiry date

Name on card: _____

Cardholder's signature: _____

13. Application for FPM Training Checklist

When submitting the application for FPM training form, please provide the following supporting documentation to enable your application to be processed.

- Certified Copy* (in English) of your qualifying Medical Degree showing date of graduation
- Certified Copy* (in English) of your primary specialist qualification showing date of graduation or letter from the primary college certifying the applicant is a current trainee having completed three years of training and not subject to any formal remediation review process.
- Certified Copy* of your birth certificate or identity page of your current passport
- Passport-size photograph taken within the previous 12 months
- Certified copy* of your current Medical registration
- If applicable, please attach a copy of your Marriage Certificate, Change of Name Note or your Medical registration indicating a change of name.

***If you are submitting a photocopy of an original document, it must be certified by Justice of the Peace (or equivalent official if outside Australia).**

The photocopy must have the following information written:

"Certified True Copy of Original Document"
Date of certification
Signature of certifier
Name and Position of the certifier

Library User Agreement

User Agreement for Document Supply Requests made via Electronic Mail

Personal Information

Family Name: _____ First Name: _____

Email Addresses

Primary:_____

Secondary: _____

Declaration

Agrees with the Library that:

1. All copies requested by me under this agreement are required for the purpose of the research or study,will not be used for any other purpose, and have not previously been supplied to me by the library.
2. The declaration in clause 1 applied to all requests made by me in accordance with clause 5.
3. The library may treat as signed by me any e-mail request and declaration made under subsection 49(1) of the Copyright Act 1968 records that it was sent from my email address
4. I understand that it is an offence under section 203F of the Act to make a declaration under section 49 that I know, or ought reasonably to know, is false or misleading in a material particular, and I will not allow any requests to be signed in a manner provided under clause 3(above) without my authority.
5. All e-mail requests and declarations must include at least the following declaration as well as the requestors college ID:

This request is made pursuant to my user agreement with the Library - Australian and New Zealand College of Anaesthetists.

I declare that any copy requested is required for the purpose of research or study, will not be used for any other purpose, and has not previously been supplied to me by the library.

Signature: _____ Date: _____

Send the completed form and attached documents to:

Faculty of Pain Medicine
PO Box 6095
ST KILDA ROAD CENTRAL
VIC 8008 AUSTRALIA

fpm@anzca.edu.au
Fax: +61 3 9510 6786