



MEDICAL BOARD OF WESTERN AUSTRALIA

Registration: Sponsoring Hospital/Organisation Application Form

FORM S

PLEASE NOTE FORM MUST BE COMPLETED IN FULL BY SPONSORING HOSPITAL OR ORGANISATION

- | | | |
|---|---|--|
| <input type="checkbox"/> Medical Teaching | <input type="checkbox"/> Medical Research | <input type="checkbox"/> Postgraduate Training |
| <input type="checkbox"/> Unmet Area of Need | <input type="checkbox"/> Recognised Specialist Quals & Exp | <input type="checkbox"/> Supervised Clinical Practice |
| <input type="checkbox"/> Rural & Remote GP | <input type="checkbox"/> Temporary Reg in the Public Interest | <input type="checkbox"/> Foreign Spec - Further Training |
| | <input type="checkbox"/> General Registration | <input type="checkbox"/> Intern |

† If applying for an "UNMET AREA OF NEED" position you must check with the Department of Health Western Australia to ensure that the location you have applied for has a current determination (*This section must be completed for consideration*)

Unmet Area of Need Determination Number: Determination current to:

- Initial
 Registration
 Transfer
 Extension
 Site Extension

Registration Number	<input style="width: 100%;" type="text"/>	Proposed Board Meeting Date	<input style="width: 100%;" type="text"/>
Applicant (full name)	<input style="width: 100%;" type="text"/>	Dates Requested	<input style="width: 100%;" type="text"/>
Sponsoring Hosp/Org	<input style="width: 100%;" type="text"/>	Contact Person & Position	<input style="width: 100%;" type="text"/>
Peripheral Locations	<input style="width: 100%;" type="text"/>	Telephone No	<input style="width: 100%;" type="text"/>
Position (of applicant)	<input style="width: 100%;" type="text"/>	Dr's Supervisor/s	<input style="width: 100%;" type="text"/>
Primary Medical Degree	<input style="width: 100%;" type="text"/>		
Additional Qualifications	<input style="width: 100%;" type="text"/>		

Previous Registration in Australia No Yes (complete, if yes) State/s

Total time registered in Aust

Registration Category Previous Location

Previous Position

Details

REQUIRED DOCUMENTS * essential requirements (application will be returned if not included)

INITIAL APPLICATION

Standard Pathway CA Pathway Specialist Pathway

	Attached	Notes	Ref
* Initial Application Fee (\$300.00)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
* Curriculum Vitae (refer to requirements on page 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
* Two written professional referee reports	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
* National ELP Requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Result	
* Position Description (Form AD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
* AMC MCQ (for Standard Pathway)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date Passed	
* Advanced Standing Certificate (for CA Pathway)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
* College Assessment (for Specialist Pathway)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Post Grad Training Program (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Hospital approval letter (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
AMC Clinical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date Passed	

EXTENSION

	Attached	Notes	Ref
Performance reports (Form AH) (minimum of two)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Satisfactory	
Provisional Registration Fee if applicable (\$50.00)	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		

SITE EXTENSION

Additional site/s required:	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
Provisional Registration Fee if applicable (\$50.00)	<input type="checkbox"/> Yes <input type="checkbox"/> N/A

(MEDICAL BOARD USE ONLY)

Comments

FORM CHECKED: (all requirements attached)

Date:

By:

Endorsed by Director of Clinical Services:

NAME

(Please print clearly)

Sign

(must be endorsed, unsigned forms will be returned)

CURRICULUM VITAE: *minimum requirements*

Required Information	Details	Advice
1. Personal Information:	<ul style="list-style-type: none"> • full name • address • email address • telephone 	
2. Secondary Education:	<ul style="list-style-type: none"> • School • City and Country • Language of Instruction 	
3. Qualifications:	<ul style="list-style-type: none"> a) Medical Degree <ul style="list-style-type: none"> i) Date Awarded ii) University b) Postgraduate Qualifications <ul style="list-style-type: none"> i) Date awarded ii) Awarding authority c) Recent Life Support Training 	
4. Detailed Practising History	Current and previous positions: <ul style="list-style-type: none"> • Dates (month/year) • Position Title • Responsibilities • Facility • City/State/Country 	You must provide a continuous history, beginning with your internship and including rotations completed. Any gaps in your work history must be accounted for; e.g. <i>Jan '98-Feb '99 - Maternity Leave.</i>
5. Current Licensing/ Registration Authorities:	<ul style="list-style-type: none"> • Jurisdiction • Licence/Registration Number 	You must provide details for <i>every</i> jurisdiction in which you are currently licensed or registered.
6. Previous Licensing/ Registraiton Authorities:	<ul style="list-style-type: none"> • Jurisdiction • Licence/Registration Number 	You must provide details for <i>every</i> jurisdiction in which you are <i>have ever</i> been licensed or registered.