

PR-005

FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ABN 82 055 042 852

FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE

THIS FORM MUST BE COMPLETED FULLY INCLUDING ALL RELEVANT SIGNATURES AND RETURNED TO THE FACULTY OF PAIN MEDICINE WITH ALL OTHER FORMS OF ASSESSMENT WITHIN THREE MONTHS OF COMPLETION OF YEAR OF TRAINING IN ORDER FOR THIS TRAINING TO BE ACCREDITED.

SURNAME: OTHER NAMES:

MULTIDISCIPLINARY PAIN CENTRE(S): DATES OF APPOINTMENTS:
(FACULTY APPROVED)

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.....
.....

OTHER (PLEASE STATE)

.....
.....
.....

LEAVE (IN WEEKS)

.....

Address for future notices: Signature of Candidate:

.....

Signature of Supervisor of Training/Medical Director

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I HAVE COMPLETED THE REQUIREMENTS OF ASSESSMENT FOR FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE AS SET DOWN IN THE FACULTY OF PAIN MEDICINE, ANZCA, REGULATIONS, AND HAVING NOW COMPLETED THE REQUIRED PERIOD OF TRAINING IN AN APPROVED POST, I HEREBY APPLY FOR ADMISSION TO FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Signature of Candidate: Date:

PLEASE ENSURE THAT DATES OF APPOINTMENTS AND THE DURATION OF APPOINTMENTS IN WEEKS ARE CORRECT AND THE FORM APPROPRIATELY SIGNED

DETAILS ON REVERSE MUST BE COMPLETED

FOR OFFICE USE ONLY

We certify that this candidate has met all the assessment requirements and recommend the award of Fellowship of the Faculty of Pain Medicine

.....Dean

.....Censor

.....Date

New Zealand Privacy Act 1993:

1. You should be aware that:
 - (a) The personal information concerning you provided to the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (the "Faculty") contained in this application or otherwise obtained or provided to the Faculty in the course of your training, examination and application for Fellowship of the Faculty is provided and may be held, used and disclosed by the Faculty for the purpose of assessing and administering your training, determining your eligibility for examination and administering, maintaining and processing your application for Fellowship of the Faculty of Pain Medicine, for publicly notifying the results of your examination or application and communicating with you for any purpose.
 - (b) The personal information provided in this proposal is collected by and will be held by the Faculty of Pain Medicine, whose address is 630 St Kilda Road, Melbourne, Vic 3004, Australia.
 - (c) If you fail to provide any information requested in this application the Faculty may be unable to process, administer, maintain or accept your training, examination or application for admission to Fellowship of the Faculty of Pain Medicine.
 - (d) You have the right under the Privacy Act 1993 to obtain access to and correct any personal information held by the Faculty concerning you.

I certify that:

- (i) I am free of chemical dependency
- (ii) I have no illness which would preclude the safe practice of pain management

I acknowledge that any drug or chemical dependency by me or condition which precludes the safe practice of pain management may result in the suspension or termination of my training at any time and prevent my admission to Fellowship of the Faculty of Pain Medicine.

Signature:.....

Date:.....