

FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852

FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE
APPLICATION FOR REGISTRATION

SURNAME:
(Block Letters)

OTHER NAMES:

*PRESENT ADDRESS:

.....

.....

TELEPHONE NO. (H) (W)

EMAIL ADDRESS:

*PERMANENT ADDRESS:

.....

.....
** Please notify immediately of any change of address*

DATE OF BIRTH: PLACE OF BIRTH:

QUALIFYING DEGREE OR DIPLOMA:

DATE OF GRADUATION:

UNIVERSITY:

Please attach documentary evidence, e.g. Photocopy of Testamur

OTHER DEGREES AND DIPLOMAS HELD:

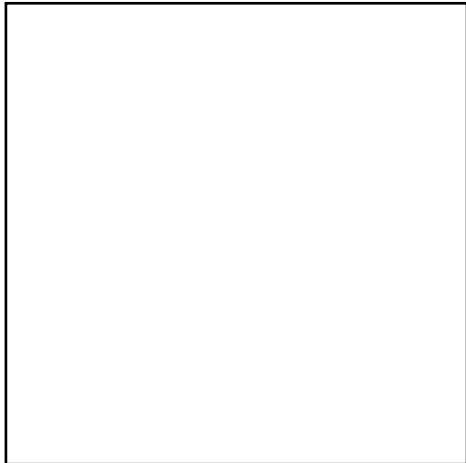
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I agree to comply with requests from the Faculty for information regarding my training and to provide any documentation determined as necessary by the Faculty from time to time.

SIGNATURE:

DATE:

DETAILS ON REVERSE MUST BE COMPLETED



Attach Photograph Here
5cm x 5cm

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FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE

HISTORY OF TRAINING COMPLETED

1. **ARE YOU CURRENTLY TRAINING TOWARDS FELLOWSHIP OF ANY OF THE FOLLOWING?** YES NO

ANZCA, RACP, RACS, RANZCP, AFRM (RACP)
 Please circle relevant College/Faculty

a) **How many years of training towards your primary specialty have you undertaken?** _____ YEARS

b) **How many years are still required before you complete your training towards your primary specialty training?** _____ YEARS

ANZCA TRAINEES ONLY -
 Are you currently registered for your PFY / ATY3? YES NO

2. **ARE YOU A FELLOW OF:**

ANZCA	YES <input type="checkbox"/> NO <input type="checkbox"/>	RACP	YES <input type="checkbox"/> NO <input type="checkbox"/>
RACS	YES <input type="checkbox"/> NO <input type="checkbox"/>	RANZCP	YES <input type="checkbox"/> NO <input type="checkbox"/>
AFRM(RACP)	YES <input type="checkbox"/> NO <input type="checkbox"/>	OTHER (Please state)

2.1 If "Yes", year Fellowship awarded:
 Please attach copy of documentary evidence

CERTIFICATION BY DIRECTOR OF PAIN CENTRE

The trainee providing this application has been accepted into a position in a Pain Centre approved for training for Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

NAME OF APPROVED UNIT:

HOSPITAL:

DATE OF COMMENCEMENT POST:
(Trainees must be fully registered prior to commencement)

DURATION POST WILL BE HELD:

SIGNATURE:
 Medical Director, Multidisciplinary Pain Centre

DATE:

Please complete and return with your fee payment to Executive Officer, Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Vic, 3004.