



HOSPITAL: HEAD OF NEUROLOGY DEPARTMENT:

ADDRESS: TELEPHONE NO: E-MAIL:

NUMBER OF ACCREDITED CORE TRAINING POSITIONS: NUMBER OF POSITION(S) TO BE RE-ACCREDITED:

Probable Supervisors* (2) FTE Date last attended RACP Supervisor Workshop

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2

EMG Supervisor*: **Level:**..... Hours/week spent supervising

EEG Supervisor*: **Level:**..... Hours/week spent supervising

**if insufficient space please attach complete list of supervisor, including the information requested above*

YEAR(S) FOR WHICH ACCREDITATION IS SOUGHT 2021 2022 2023 2024 2025

NO. OF INPATIENTS BEDS:QUALITY ASSURANCE PROG? YES NO

ON CALL FOR EMERGENCIES DURING NORMAL WORKING HOURS? YES NO

ON CALL FOR EMERGENCIES AFTER HOURS? YES NO

NO. OF AMBULATORY CARE (OUTPATIENTS) CLINICS/WEEK:

AVERAGE NO. OF INPATIENT CONSULTATIONS/WEEK :

NO. OF PART-TIME NEUROLOGISTS IN THE DEPARTMENT:

NO. OF FULL-TIME NEUROLOGISTS IN THE DEPARTMENT:

NO. OF EEGs/WEEK NO. OF EMGs/WEEK NO. OF EPs/WEEK

YES NO CT SCAN (*)

YES NO ANGIOGRAPHY: (*)

YES NO READY ACCESS TO MRI: (*)

YES NO WEEKLY NEURORADIOLOGY REVIEW MEETINGS: (*)

YES NO MONTHLY NEUROPATHOLOGY TEACHING SESSION: (*)

YES NO NEUROSURGERY SERVICE: (*)

YES NO PSYCHIATRY SERVICE: (*)

YES NO ONE SUPERVISED NEUROREHABILITATION SESSION/WEEK FOR 6 MONTHS:

() If off-site please nominate facility*

(*)

BRAIN SCHOOL: Quarantined Time for trainee participation in National Brain School **Yes No**

Location of video-conferencing facilities at hospital: (including contact details of technical support person):

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*Will Hospital or Area Health Authority allow access to these facilities at no cost to trainee: **Yes No***

Other sub-specialty training available? YES NO If YES, nominate specialties:

Please indicate any changes in resources since the last accreditation:

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SIGNED: **NAME:** **DATE:** **POSITION:**

Office Use Only: Reaccredited: Yes No Date..... Accredited by: (Please print name)

Comment:.....