



**APPLICATION FOR ACCREDITATION
OF CORE TRAINING POSITION(S) IN NEUROLOGY**
Australian and New Zealand
Association of Neurologists
Green form: Feb 2020

Please return this completed form to anzan@anzan.org.au, together with a covering letter with information about the rationale for the application that includes:
(1) the need for the job
(2) the educational opportunities for the new post
(3) a proposed timetable.

HOSPITAL: HEAD OF NEUROLOGY DEPARTMENT:

ADDRESS: TELEPHONE NO: E-MAIL:

NUMBER OF ACCREDITED CORE TRAINING POSITIONS:

Probable Supervisors* (2)	FTE	Date last attended RACP Supervisor Workshop
1
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):
.....

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:
.....

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

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

Comment:.....