APPLICATION FOR **ACCREDITATION**
OF CORE TRAINING POSITION(S) IN NEUROLOGY

Australian and New Zealand Association of Neurologists

Green form: Feb 2021

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 2022 ☐ 2023 ☐ 2024 ☐ 2025 ☐ 2026 ☐

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:.....