THE HONG KONG COLLEGE OF FAMILY PHYSICIANS
Application Form for Accreditation / Re-accreditation as Training Centre for <u>Basic Training (Community Based)</u> in Family Medicine

☐ Application of Training Centre Accreditation
☐ Application of Training Centre Re-accreditation
Expiry Date of Accreditation (mmm/yyyy): ______________________________

1. Name of Practice: ______________________________

2. Address: ______________________________
____

3. Telephone: ____________________ Email: ____________________

4. Department head /Chief of Service: ______________________________

5. Centre in Charge: ______________________________

6. Any **<u>Basic</u>** Trainee(s) working in the practice in the preceding 12 months:

   Yes [ ] No [ ]

7. Any **<u>Basic</u>** Trainee(s) working in the practice in the coming 12 months:

   Yes [ ] No [ ]

Those with no Basic Trainees in the preceding/coming 12 months, will be automatically accredited as Provisional training centre and no application is needed. Please return this page to BVTS for further arrangement. Should you have any queries, you are welcome to contact our secretariats at 2871 8899 or <u>BVTS@hkcfp.org.hk</u>.

If yes, please proceed to the next page.

TRAINING SUPERVISOR IN CHARGE (Same as 4 above)
(Please make photocopy of this page if there is more than one supervisor)

1. Name: .... (☐ In Charge)

   Place and Year of Graduation: ....

2. Other Qualification (and year obtained): ....

   ....

3. Years of Experience in General Practice: ....

4. Number of Years in Present Practice (Please state the number of hours/week on-site):

   ....

5. Past Experience in Teaching/Training (if any): ....

6. Past Experience in Research (if any): ....

7. FHKAM (Family Medicine): *NO / YES ....
   (Year obtained)

8. Status in HKCFP:

   Fellow [ ] Full [ ] None [ ]

   Associate Member [ ] Affiliate Member [ ]

9. Do the other members of your practice agree to have a trainee in the practice?

   *Yes / *No / *Not applicable

10. Are there other members of your practice who may be clinical supervisors?

    *Yes / *No / *Not applicable

    If yes, please provide details of items 1 to 8 for each of them on supplementary sheets.

    ** delete as appropriate*

THE PRACTICE

11. Types of Practice:

Hospital Authority Hospital: HKE [ ] HKW [ ]

KC [ ] KE [ ] KW [ ]

NTE [ ] NTW [ ]

Department of Health [ ] Institutional [ ] University [ ]

Private Hospital [ ] Private Solo [ ] Private Group [ ]

Others [ ] ....

Please specify

12. Total number of doctors working in the practice with regular pattern (providing general practice service):

	FM Specialist (FHKAM)	Higher trainee	Others *please specify*
Full Time			
Part time/Sessional			

Maximum number of Trainees intended to take:

Basic: ....

Higher: ....

13. Please describe the main geographical, social and environmental features of the practice, including any local health problems: e.g. occupational problems

PRACTICE ORGANIZATION

14. Is there an appointment system?

    Yes [ ] Full* / Partial*

    No [ ]

15. What is the normal booking rate per hour? ....

16. How many appointments are available each week in the practice?

    ....

17. Is there a medical record system? Yes [ ] Manual* / computerized* / both*

18. Does your practice have an age/sex register and disease register?

    Age/Sex Register Yes [ ] No [ ]

    Disease Register Yes [ ] No [ ]

19. What special equipment for diagnosis and treatment are available at the practice?

    e.g. ECG, peak flow meter, cauterisation machine

    ....

    ....

    ....

    ....

20. Does your practice provide house calls/home visits?

    Yes [ ] No [ ]

    If yes, please state the average number of visits per month ....

STAFF

21. Total number of Paramedical and supporting staff

	Total number (FTE if some part time)
Receptionist/Shroff/Clerical staff	
Nurses: (Rank/No.) e.g. APN, RN, EN	
Clinic assistant	
Pharmacists	
Dispenser	
Allied Health (Pls specify type and no.)	
Supporting staff (workman, etc)	

WORKLOAD for trainees and Supervision

22. Please enter the following statistics:

	Mon	*Tue*	*Wed*	*Thur*	*Fri*	*Sat*	*Sun*
A.M.							
P.M.							

23. Supervision:

Direct Supervision time from trainer: ____________hours/week

Protected session for Structural Education Program (Training Seminar):
Yes [ ] No [ ]

EDUCATIONAL FACILITIES and ACTIVITIES

24. Does your practice have Training resources in General Practice or Family Medicine?

Yes [ ] Library* / Free access to FM Journals* / Others:

No [ ]

25. Does your practice allow time for continuing medical educational activities?

Yes [ ] No [ ]

Weekly / Monthly / Others: ____

26. Does your practice organize the following educational activities?

a. Small Group Discussion [ ]

b. Tutorial [ ]

c. Lecture/Seminar [ ]

d. Journal Club [ ]

e. Research Club [ ]

f. Undergraduate Teaching [ ]

g. Video-Tape Viewing Sessions [ ]

h. Others (Please Specify) ____

____

____

I, on behalf of ______________________________, apply for accreditation as a training centre for Community Based Training of the Vocational Training Programme organized by the Hong Kong College of Family Physicians. My preference timeslots for the visit would be:

	Mon	***Tue***	***Wed***	***Thur***	***Fri***	***Sat***	***Sun***
A.M.							
P.M.							

Signature : ______________________________

Name : ______________________________

(Block Letters, Please)

Date : ______________________________

- END -