**CCrISP® INSTRUCTOR APPLICATON FORM**

**Please provide your personal details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Prefix:** | Dr [ ]  Miss [ ]  Mr [ ]  Mrs [ ]  Ms [ ]  Prof[ ]  Other [ ]   | **First name(s):** |  |
| **Middle name(s):** |  | **Last name:** |  |
| **Preferred name:** |  |
| **Address:** |  |
| **State:** |  | **Postcode:** |  |
| **Email:** |  |
| **Mobile:** |  | **Work tel:** |  |
| **Home tel:** |  | **Gender:** | **Male** | **[ ]**  |
|  |  |  | **Female** | **[ ]**  |
| **Please email a photo along with this application form** |

**Please specify your medical discipline:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **[ ]**  | Anaesthetics |  | **[ ]**  | Oral & Maxillofacial Surgeon |
| ***[ ]***  | Emergency Medicine |  | **[ ]**  | Physician |
| **[ ]**  | General Practice |  | **[ ]**  | Surgical; specialty: |       |
| **[ ]**  | Intensive Care |  | **[ ]**  | Other; please specify: |       |

**Education:**

|  |  |
| --- | --- |
| Year of Graduation: |       |
| Awarding Organisation: |       |
| Qualifications: |       |

**Recent clinical appointments:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date (most recent first) | Organisation | State | Position (ie Registrar, Consultant.) |
|       |       |  |       |
|       |       |  |       |
|       |       |  |       |

**Please specify your current status:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **[ ]**  | SET/accredited trainee |  | **[ ]**  | Non SET/non-accredited trainee |
| **[ ]**  | IMG |  | **[ ]**  | Fellow |
| ***[ ]***  | General Practitioner |  | ***[ ]***  | Other; please specify: |  |

**Nomination and references:**

|  |  |  |
| --- | --- | --- |
| **Did you self-nominate?** | [ ]  Yes | [ ]  No |
| If no, who were you nominated by? |
| Name:       | Email:       | Mobile:       |
| **Reference:** (someone who can comment on your attributes to teach) |
| Name:       | Email:       | Mobile:       |

|  |
| --- |
| **What are your reasons for applying to become a CCrISP® instructor?** (Why do you want to be an instructor? What do you hope to achieve?) |
|       |

|  |
| --- |
| **What characteristics do you have that you believe would make you a good CCrISP instructor?** |
|       |

|  |
| --- |
| **What is the nature of your current involvement in the care of critically ill surgical patients?** |
|       |

|  |
| --- |
| **Please outline your teaching experience:** |
|       |

|  |
| --- |
| **CCrISP Instructor Statement**I recognise that the inclusion of my name on the panel of CCrISP® Instructors is dependent upon assessment at the Instructor Course.I       agree that upon successful completion of the CCrISP® Instructor Course I will:**1.** Complete my training by attending a CCrISP course as an Instructor Candidate within 12 months**2**. I will be available to instruct on at least two CCrISP courses each year**3.** I will commit to teach CCrISP for a minimum of four yearsSignature       Date:      **RACS Privacy Statement**RACS is collecting the information on this form for the purpose of processing your course registration. This information may be disclosed to those responsible for the administration and conduct of the course including external parties who provide administrative and organisational support. The College may also need to verify the information provided on this form with external institutions or individuals, and gather additional information in order to process your registration. We may also disclose personal information where we are required to do so by law. If you fail to provide this information the College will be unable to process your registration. You may gain access to the personal information you have provided on this form and other personal information we hold about you by contacting the College’s Privacy Officer on 03 9249 1200. You also have the right to update and correct any personal information we hold about you. I consent to the information on this form being used and disclosed as stated.Signature       Date:       |

|  |
| --- |
| **Please ensure you have completed the following before you submit your application:**[ ]  Emailed photo to ccrisp@surgeons.org[ ]  Signed CCrISP® Instructor statement [ ]  Signed RACS privacy statement [ ]  Attached reference from CCrISP Instructor (if available)**Please return this form to:**CCrISP® Program AdministratorThe Royal Australasian College of SurgeonsCollege of Surgeons Gardens250-290 Spring StreetEast MelbourneVIC 3002Australiaccrisp@surgeons.org Or fax to **+61 3 9249 1298** |

© and all other intellectual property rights in the original CCrISP® course materials belong to the Royal College of Surgeons of England