

SECTION 7 ... RESEARCH AND PUBLICATIONS

RESEARCH INVOLVEMENT BY CANDIDATE

Note: The fields below are institution specific and need not be completed if not required by your institution.

GOOD CLINICAL PRACTICE (GCP) CERTIFICATION

Completed	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Completed	<input type="text" value="YYYY / MM / DD"/>
Certification Authority	<input type="text"/>
<i>(Append GCP Certificate)</i>	

RESEARCH METHODOLOGY COURSE

Completed	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Completed	<input type="text" value="YYYY / MM / DD"/>
Course conducted by	<input type="text"/>
<i>(Append Attendance Certificate)</i>	

OTHER RESEARCH RELATED COURSES ATTENDED

Include other courses attended (e.g. statistics courses) here.

DATE	COURSE	CONDUCTED BY
YY/MM/DD		
YY/MM/DD		
YY/MM/DD		

THE RESEARCH COMPONENT OF THE MASTERS IN MEDICINE (MMed)

The table below is a guide for ensuring that you are progressing in respect of your research. This may vary in your institution.

Where possible, append appropriate certificates, letters of approval, etc.

STEPS	DATE	SUPERVISOR SIGNATURE
CHOICE OF SUBJECT	YY/MM/DD	
CHOICE OF RESEARCH TOPIC	YY/MM/DD	
LITERATURE SEARCH	YY/MM/DD	
DEVELOPMENT OF RESEARCH HYPOTHESIS	YY/MM/DD	
COMPLETION OF PROTOCOL	YY/MM/DD	
PRESENTATION AT RESEARCH MEETING	YY/MM/DD	
PROTOCOL REVISION	YY/MM/DD	
STATISTICAL PLANNING	YY/MM/DD	
PLANNING OF BUDGET	YY/MM/DD	
TRANSLATION OF CONSENT	YY/MM/DD	
SUBMISSION TO POST-GRADUATE COMMITTEE (or equivalent)	YY/MM/DD	
POST-GRADUATE COMMITTEE (or equivalent) APPROVAL	YY/MM/DD	
APPROVAL BY ETHICS COMMITTEE	YY/MM/DD	
INSTITUTIONAL APPROVAL (as appropriate)	YY/MM/DD	
OTHER DEPARTMENTS/ROLE PLAYERS INFORMED	YY/MM/DD	
DATA COLLECTION COMPLETED	YY/MM/DD	
DATA ENTRY AND PROCESSING	YY/MM/DD	
MANUSCRIPT / THESIS COMPLETION	YY/MM/DD	
PUBLICATION	YY/MM/DD	
DEGREE AWARDED	YY/MM/DD	

INVOLVEMENT IN OTHER RESEARCH PROJECTS

DETAILS OF PROJECT	INVOLVEMENT	DATE	PRINCIPAL INVESTIGATOR SIGNATURE & NAME

JOURNAL PUBLICATIONS BY CANDIDATE:

(Attach copy of publication)

NO.	AUTHORS (list fully in order)	FULL TITLE	JOURNAL	VOL. (NO.)	PAGES
1					
2					
3					
4					
5					
6					

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SECTION 8 ... OTHER ACTIVITIES

TEACHING ACTIVITIES

Record here all formal and informal teaching of medical students, interns, medical officers, other registrars, Nurses, allied health personnel and any other individuals. Record details of the teaching session and reflective comments if you find them useful in your learning and professional development.

DATE	TEACHING ACTIVITY	DETAILS	REFLECTIVE COMMENTS
YY/MM/DD			

DATE	TEACHING ACTIVITY	DETAILS	REFLECTIVE COMMENTS
YY/MM/DD			

PROFESSIONAL ACTIVITIES

Record here all activities in respect of committees in which you are involved, management structures that you have participated in, and leadership roles that you may have assumed.

DATE	STRUCTURE	ACTIVITY
YY/MM/DD		

COMMUNITY / OUTREACH ACTIVITIES

Record here all activities that you have participated in as part out outreach or community development.

DATE	STRUCTURE	ACTIVITY
YY/MM/DD		

CRITICAL INCIDENT MONITORING

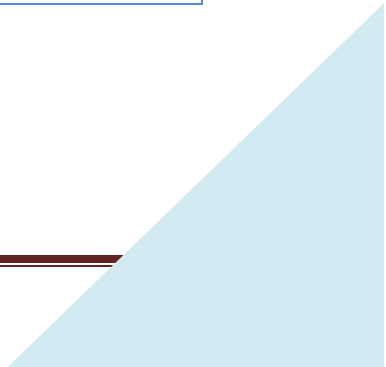
Record critical incidents that you experience or are aware of that will help your learning. Include major and minor incidents that occur. e.g. drug administration errors, failed/difficult intubation, complications of regionals, death on the table.

Please ensure that you do not include any confidential patient information or names of individuals involved.

DATE	CRITICAL INCIDENT	NOTES ON LESSON LEARNED OR REFLECTION
YY/MM/DD		

DATE	CRITICAL INCIDENT	NOTES ON LESSON LEARNED OR REFLECTION
YY/MM/DD		

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SECTION 9 ... ASSESSMENTS

Record or append all assessments here.

Such assessments to include:

1. Assessment of Trainee by Supervisor / Module Supervisor

2. Assessment of Module / rotation by Trainee

There are institutional variations in these assessments. Include what is used at your training centre.

At a minimum, such In-Training Assessment (ITA) forms should include:

- i. Period of assessment
- ii. Module/Block/Rotation completed
- iii. Supervisor/s of training
- iv. Date of assessment
- v. Result of assessment (e.g. exceeds requirements, meets requirements, does not meet requirements)
- vi. Evidence of feedback / remedial action if necessary
- vii. Name of assessor
- viii. Signature of assessor

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SECTION 10 ... DECLARATIONS OF COMPLETION OF TRAINING PERIODS

Appropriate declarations of completion of training need to be completed and signed by both the Trainee and Supervisor. Four such declarations need to be completed, one for each year of training.

In addition, the supervisor needs to complete the required forms when the candidate enrolls for the Part II of the FCA.

Copies of the declaration form are to be held by the academic department.

DECLARATION ON COMPLETION OF TRAINING – YEAR 1

I,hereby do solemnly declare that all information contained in this PORTFOLIO OF LEARNING is a true and accurate record of my professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Candidate:.....

Name of Candidate:.....

Trainee Number:

Date:

I,hereby declare that I have inspected the information contained in this PORTFOLIO OF LEARNING in respect of the Trainee’s professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Academic Head of Department:.....

Name of HOD:

Date:

Departmental / University
Stamp

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DECLARATION ON COMPLETION OF TRAINING – YEAR 2

I,hereby do solemnly declare that all information contained in this PORTFOLIO OF LEARNING is a true and accurate record of my professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Candidate:.....

Name of Candidate:.....

Trainee Number:

Date:

I,hereby declare that I have inspected the information contained in this PORTFOLIO OF LEARNING in respect of the Trainee’s professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Academic Head of Department:.....

Name of HOD:

Date:

Departmental / University
Stamp

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DECLARATION ON COMPLETION OF TRAINING – YEAR 3

I,hereby do solemnly declare that all information contained in this PORTFOLIO OF LEARNING is a true and accurate record of my professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Candidate:.....

Name of Candidate:.....

Trainee Number:

Date:

I,hereby declare that I have inspected the information contained in this PORTFOLIO OF LEARNING in respect of the Trainee’s professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Academic Head of Department:.....

Name of HOD:

Date:

Departmental / University
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DECLARATION ON COMPLETION OF TRAINING – YEAR 4

I,hereby do solemnly declare that all information contained in this PORTFOLIO OF LEARNING is a true and accurate record of my professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Candidate:.....

Name of Candidate:.....

Trainee Number:

Date:

I,hereby declare that I have inspected the information contained in this PORTFOLIO OF LEARNING in respect of the Trainee’s professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

Signature of Academic Head of Department:.....

Name of HOD:

Date:

Departmental / University
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DECLARATION BY ACADEMIC HEAD FOR TRAINEE TO ENROL IN EXAMINATION

I hereby declare that I have inspected the information contained in this PORTFOLIO OF LEARNING in respect of the Trainee's professional experience, education and training from dd / mm / cccc to dd / mm / cccc representing the period of training for the Anaesthetic qualification.

I further certify that the Trainee has fulfilled the requirements below:

The trainee has successfully completed/is exempt from FCA Part I examination	YES	NO
The trainee has completed at least three years following full registration by the Health Professions Council of South Africa as a medical practitioner.	YES	NO
The trainee will have held a fulltime appointment as a registrar in the Department of Anaesthetics in a teaching hospital or teaching hospital satellite department for at least THIRTY-SIX MONTHS at the time of writing the examination.	YES	NO
The trainee has been assigned for three months of the above period to an Intensive Care Unit on a fulltime basis.	YES	NO
The trainee has successfully completed all the Departmental and Faculty requirements in respect of training in Anaesthesiology.	YES	NO

Signature of Academic Head of Department:.....

Name of HOD:

Date:

Departmental / University
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