Alberta's Rural Health Professions Action Plan

# PETER K. LINDSAY ENRICHMENT TRAINING APPLICATION



***Please Print All Information Requested (Except Signature)***

**Name:**

*Last* *First* *Middle* *Maiden*

**Mailing Address:**

*Number* *Street* *City* *Prov.* *Postal Code*

**Telephone**: Work (_____)_____ Home (_____)_____ Mobile (_____)_____

**Email:**_____

**Place of Birth**: _____ Rural ☐ Urban ☐

**Date of Birth** (dd/mm/yyyy) _____/_____/_____

**CPSA Practice Permit No.** _____

**CMPA No**. _____ **Expiry Date**_____

**S.I.N.** _____ OR **Bus. No.** _____

**Graduate of which Medical School?** _____ **Year** _____

**Certificate in Family Medicine**? ❑ No ❑ Yes Year _____ **Royal College Fellowship?** ❑ No ❑ Yes Year _____

**AHS Zone in which you currently have as your primary zone and privileges:** _____

**Category of AHS Medical Staff Appointment**: Active ☐ Probationary ☐ Temporary ☐ Community ☐ Locum Tenens

**List privileges currently held**:

Surgery _____ General Medicine _____

Anaesthesia _____ Paediatrics _____

Obstetrics _____

Cardiology: ECG ☐ Cardiac Stress Testing ☐

Emergency: ❑ Yes ❑ No If yes, are you a Certificate in Emergency Medicine? ❑ No ❑ Yes

Other _____

**Availability:** From (dd/mmm/yyyy) _____/_____/_____ to (dd/mmm/yyyy) _____/_____/_____

**Objectives:** Describe briefly what training you wish to pursue and at least three objectives that you hope to meet as a result of this training. At least one objective should relate to the services you provide through Alberta Health Services (AHS). Please be as specific as possible; e.g. "I wish to understand Palliative Care" is too general and difficult to assess. RPAP Skills Brokers can help with developing your objectives. Please summarize any additional information necessary to describe your need for this specific training and indicate all experience to date in this particular discipline.

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## AHS Zone/ Preceptor

Has your AHS medical leader identified a need for this training? ❑ No ❑ Yes

Have they agreed to provide the necessary letters of support for your training? ❑ No ❑ Yes

Will AHS cover any costs required to practice the new skills when your training is complete? ❑ No ❑ Yes

PLEASE NOTE: Documentation will be required before approval of your application.

Do you require locum coverage? ❑ No ❑ Yes

Has a preceptor agreed to provide the training? ❑ No ❑ Yes

Preceptor's Name _____

Telephone: Work (____)_____ Mobile (____)_____

If no preceptor has agreed to provide training, we will first forward your application when accepted to the Faculty liaison at the Universities of Calgary or Alberta.

PLEASE BE ADVISED: The duration of your training program will be influenced by your stated objectives and the opinion of the preceptor.

## Application Form Release

*(Please Read Carefully)*

I, _____ [name], agree that:

I may be required to maintain a log of procedures performed, cases seen and treated or referred, personal assessment of my training program and Alberta Health Services (AHS) response to my training.

Both the AHS medical leader and I will be asked to comment on the program and areas for improvement. Therefore, I may be contacted in the future by the RPAP or its agents to assess the quality and effectiveness of the Peter K. Lindsay Enrichment Training program, and I agree to be contacted and to participate in any evaluation for this purpose.

The personal information collected from and during this application may be used by RPAP for program administration, payment and evaluation of the Peter K. Lindsay Enrichment Program.

I authorize the investigation of all statements contained in this application. I understand that any misrepresentation or omission of facts called for may be cause for rejection of my application or removal from training at any time without any previous notice. I hereby give the RPAP permission to contact medical schools, references, and others.

I also understand that the honorarium provided to me by the RPAP is to assist with the costs associated in leaving my practice to gain the additional skills needed in my community, and that no agency, partnership, or employment relationship exists or will be created between myself and RPAP. The honorarium does not include any benefits such as health care insurance, life insurance or vacation entitlement. Maintenance of such benefits or payment of taxes and pensions is my own responsibility.

I hereby release, indemnify and hold harmless the RPAP, the Alberta Minister of Health, their respective employees, agents and contractors from any and all liability, claims, demands, actions and damages whatsoever, whether arising in contract or in tort and whether caused by or contributed to by any negligence, breach of duty or wilful misconduct of myself, RPAP or any employee, agent, contractor, officer or director of RPAP, including those that may arise directly or indirectly out of any acts or omissions of myself during my period of training. If my application is approved, I may be required to sign and further release in the form provided by RPAP.

**I commit to return to rural practice in Alberta after my enrichment training is completed**.

Signature: _____ Date: _____