

## APPLICATION FORM

QLD70521

### Instructions

Section A: All applicants must complete this section.  
 Section B: Only self-employed applicants should complete this section.  
 Section C: Only employees (not self-employed) applicants should complete this section.  
 Sections D, E & F: All applicants must complete these sections.

Please complete the relevant sections of this application form and return to your PEPA Manager:  
 Centre for Palliative Care Research and Education  
 Level 7, Block 7,  
 Royal Brisbane and Women's Hospital  
 Herston Queensland 4029

### Privacy & Confidentiality

All information provided by you in this application will be kept private and confidential. This information will only be used for the purposes of:

- Assessing your eligibility for the program
- Allocation of clinical placements
- Follow-up and post-placement support
- Program evaluation
- Confirmation of your qualifications
- Confirmation of current registration / authority to practice

*Please tick*

I understand and agree to the information I have provided to be used for the above purposes.  
 I consent to my name and contact details being forwarded to the relevant person for post-placement support activities.  
 I consent to my name and contact details and my program report, being forwarded to the PEPA National Coordination Team for program evaluation.

### Applicants Details

Title  Mr  Mrs  Ms  Dr  Other \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name(s): \_\_\_\_\_

Postal Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Next of Kin (in case of emergency) \_\_\_\_\_ Name of Next of Kin / Emergency Contact \_\_\_\_\_ Phone Number of Contact \_\_\_\_\_

### Section A: Eligibility Criteria

**Q1.** Are you currently employed (including self employed) in a health care service that provides services for people with life limiting illness?  
 Yes  No (You cannot proceed any further if you tick this box)

**Q2.** Is your registration / practising certificate current?  
 Yes - you must provide details in the space provided and attach evidence – then go to Question 4  
 No (You cannot proceed any further if you tick this box)  
 Not Applicable (for non-regulated workers/carers) – go to Question 3

Registration Number	Registering Authority	Renewal Date

**Q3.** For non-regulated workers (i.e. workers from disciplines that are not regulated under the Australian Health Practitioner Regulation Agency), please specify your current position?

<input type="checkbox"/> Aboriginal Health Worker <input type="checkbox"/> Indigenous Liaison Officer <input type="checkbox"/> Indigenous Community Worker <input type="checkbox"/> Migrant/Culturally & Linguistically Diverse Liaison Officer <input type="checkbox"/> Residential Aged Care Worker or Assistant in Nursing <input type="checkbox"/> Pastoral Care Worker <input type="checkbox"/> Chaplain <input type="checkbox"/> Other, please specify _____	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Speech Pathologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Dietician <input type="checkbox"/> Bereavement Counsellor/Coordinator <input type="checkbox"/> Paramedical Aide
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### PEPA MANAGER USE ONLY

Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_ Approved \_\_\_\_/\_\_\_\_/\_\_\_\_ PEPA Manager \_\_\_\_\_  
 Date Notified \_\_\_\_/\_\_\_\_/\_\_\_\_ Host Site \_\_\_\_\_ Placement Dates \_\_\_\_/\_\_\_\_/\_\_\_\_

**Q4.** Have you obtained a *Working with Children* card or other appropriate authority as required by state/territory legislation and local institutional policies if undertaking a placement which may involve interactions with children?

Yes, please provide details below and attach evidence  
 No (If no, please discuss with PEPA Manager to determine whether this is required for your proposed placement)

Card number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**Q5.** Are you self-employed?

Yes (Go to Section B of this application)  No (Go to Section C of this application)

**Section B: Self-employed Applicants Only**

All self-employed applicants are required to provide their own insurance per the *National Information and Application Kit*.

**Q1.** Do you have current medical indemnity/ medical defence insurance that will cover you throughout your attendance at your PEPA supervised clinical placement/s?

- Yes (please attach a "Certificate of Confirmation")  No (You cannot proceed any further if you tick this box)

**Q2.** Do you have current Work Cover insurance that will cover you throughout your attendance at the PEPA supervised clinical placement/s?

- Yes (please attach a "Certificate of Confirmation")  No (You cannot proceed any further if you tick this box)

**Q3.** Do you currently have a Work Cover Claim?

- Yes (go to question 4)  No (Go to the Participant Declaration for this section)

**Q4.** Is a PEPA placement consistent with the current Work Cover Certificate of Capacity provided by your doctor?

- Yes (please attach documentary evidence)  No (You cannot proceed any further if you tick this box)

**Participant Declaration:** I declare that my insurances (indicated above) are current and cover me throughout the period of my PEPA Placement, and a copy of current "Confirmation Certificate" for my medical indemnity insurance and Work Cover is attached. In signing this declaration I agree to comply with the responsibilities outlined in the *PEPA Information and Application Kit*.

**Please Note:** You are required to attach a copy of the "Confirmation Certificate" for your medical indemnity insurance and Work Cover.

Place of Work: \_\_\_\_\_

Position Title: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Self-employed person's signature Date

**Section C: Employed Applicants (not self-employed)**

Place of Work: \_\_\_\_\_

Position Title: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Managers Declaration**

Manager's Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

Email: \_\_\_\_\_

**Please Note:** The following questions & declaration are to be completed by the applicant's manager (employer).

**Q1.** Will the applicant be covered by your organisation's professional indemnity insurance while undertaking a PEPA Placement?

- Yes  No (Applicant cannot proceed any further if you tick this box)

**Q2.** Will the applicant be covered by your organisation's Work Cover policy while undertaking a PEPA Placement?

- Yes  No (Applicant cannot proceed any further if you tick this box)

**Q3.** Does the applicant currently have a Work Cover claim?

- Yes (Go to question 3)  No (Go to question 4)

**Q4.** If yes, is the applicant's participation in PEPA consistent with the conditions of the Work Cover Certificate of Capacity provided by the applicant's doctor? (Please note: If you have a Work Cover Claim you may not be able to participate in PEPA. Contact your local PEPA Manager for more information)

- Yes (Please attach documentary evidence of the doctor's approval for the applicant to participate)
- No

Q5. Do you support the applicant to undertake a clinical placement and provide support for the learning that will be implemented on return to the workplace?

- Yes
- No

Q6. Having read the PEPA Information and Application Kit, do you understand and agree to comply with all requirements for participation in the program?

- Yes
- No

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Manager's Signature Date

**Section D: Placement Preferences**

*Please Note: Placement preferences will be taken into account where possible.*

- |   |                                    |                                    |   |
|---|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Local palliative care service        | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |
| <input type="checkbox"/> Regional palliative care service     | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |
| <input type="checkbox"/> Metropolitan palliative care service | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |

Q1. If available, would you be interested in a mixed placement? (E.g. 1-2 days at a regional/metropolitan palliative care service and 1-2 days at your local service)?  Yes  No

Q2. What are your preferred dates / times for a placement?

\_\_\_\_\_

Q3. Are there any times that you would **not** be available for a placement?

\_\_\_\_\_

Q4. Are there any other constraints that would impact on your uptake of a placement (e.g. childcare)?

**Section E: Applicants Declaration**

If I am successful in securing a clinical placement, I understand that I may have access to information of a private and confidential nature, including information about the Host Site, its staff and patients. I understand that I have an obligation to maintain this confidentiality at all times and I declare that I will not disclose any information to any person, organisation or body, by any means (electronic, verbal, hard copy or other means).

I declare that I do not have any current or pending misconduct proceedings or health conditions that would impact on my participation in this program. Also, I declare that if I am unwell during a placement I understand that it is my responsibility to raise this with my supervisor and cease work if either a patient(s) or my own health may be compromised.

*In signing this application, I declare that the information provided by me in support of my application is true and accurate. Should I be successful, I agree to abide by the requirements of the program as outlined in the Information & Application Kit. I agree to notify the PEPA Manager should any of the information provided in this application change before or during my participation in the program.*

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section F: Applicants Checklist**

*Please complete the following checklist to ensure you have attached all the necessary documentation.*

- Copy of your current professional registration or license to practice.
- Copy of your current "Confirmation Certificate" for your medical indemnity insurance (applicable to self-employed applicants only).
- Copy of your current *Working with Children* card if appropriate

**Section G: Professional Development Points**

**Please check the following boxes & include your membership number/s if you registered with the following organisations:**

- Royal Australian College of General Practitioners (RACGP) – Membership Number \_\_\_\_\_
- Australian Council for Rural & Remote Medicine (ACRRM) – Membership Number \_\_\_\_\_

**APPLICANT'S NAME:** \_\_\_\_\_

*All applicants must complete this section. Please copy this page, and take with you to your clinical placement.*

Q1. Please provide brief details of your current role in caring for people with life-limiting illness.

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Q2. Why are you applying to undertake a PEPA placement?

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Q3. List 3 key things you want to achieve during your PEPA placement?

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Q4. How will you disseminate information about your experience to colleagues on return to your workplace?

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*Please Note:*  
*On completion of your PEPA Placement, it is a requirement that all participants implement a quality improvement activity within their workplace, within 4 – 6 weeks.*

**Examples of activities that previous participants have undertaken include:**

- *Development of new policy*
- *Development of patient assessment tools*
- *Setting up support networks*
- *In-service education*
- *Resource folders for patients and staff*
- *Establishment of a Palliative Care Committee*
- *Formal staff education*
- *Introduction of complimentary therapies to service*
- *Implement multi-disciplinary team meetings*