

## WACP/RCP educational capacity building programme Doctors as Educators application form

The information that you provide may be used in the compilation of data and reports, but the source will be kept anonymous. Please type or complete legibly in BLOCK CAPITALS. Use additional blank pages if necessary.

### Personal details

Last name / Family Name		
Forename(s)/First Name(s)		
Date of Birth		
Gender		
Correspondence address	Contact telephone number (with country code)	
	Fax number (with country code)	
	Email Address	

### Qualification details

Name and address of University/Medical School for your primary medical qualification:	Title of Qualification:
	Date started (dd/mm/yy)
	Date finished (dd/mm/yy):

Name and address of awarding body for your postgraduate qualification:	Title of Qualification:
	Date started (dd/mm/yy):
	Date finished (dd/mm/yy):

	Date conferred (dd/mm/yy):
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**Employment history: current post**

Name and address of employing hospital/institution:	Job Title & grade:
	Date started
Specialty:	

**Employment history: previous appointments**

Please list your past medical appointments. You should enter all dates in full and use additional blank sheets if necessary.				
From mm/yy	To mm/yy	Grade	Specialty	Hospital

**Teaching experience**

Your responses to the following questions will provide useful information about your teaching experience and development plans, and will enable us to tailor the Doctors as Educators programme to suit your needs:

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<p>What teaching/educational activities are you involved in (e.g. lecturing to large groups, tutoring, bedside teaching, small group teaching, assessing)?</p> <p>Please give details of your educational responsibilities for other doctors, nurses, and other health care providers at your current post in your hospital.</p>
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Please provide the number of people for whose education or training you are **directly** responsible for at the moment.

Number of trainee doctors responsible for:

Number of nurses responsible for:

Number of other health care providers responsible for:

What are your objectives for this programme? In other words, what do you want to get out of it?

What impact would you hope that such a programme will have on your teaching?

Do you have suitable internet access to follow up possible post-workshop on-line activities?

### Signature

I confirm that the information I have provided in my application is correct and true. I understand that any false declaration in any part of the application may result in a refusal of the application. I understand that the West African College of Physicians and the Royal College of Physicians reserve the right to refuse my application, or request further documentation and evidence to support my application if they feel it is necessary. I understand that the Colleges retain the right to withdraw the offer of a place in the training if any information provided in my application is found to be false or misleading at a later date. I consent to the Colleges processing and retaining the personal information contained in this application in line with its Registration under the Data Protection Act.

Signature \*

Date

\* **Electronic signatures are acceptable, as well as typing your name on the signature space. Please return the completed application form electronically to: the email address of the zonal coordinator of the applied course as written on the advert.**