

AUSTRALIAN & NEW ZEALAND ASSOCIATION OF NEUROLOGISTS

**APPLICATION FOR ACCREDITATION OF A NEW
CORE ADVANCED TRAINING POSITION IN NEUROLOGY**

HOSPITAL:

ADDRESS:

HEAD OF NEUROLOGY DEPARTMENT:

TELEPHONE NO: FAX NO:

E-MAIL:

CURRENT NUMBER OF AAN ACCREDITED TRAINING POSITIONS:

Probable Supervisors (2)

Date last attended RACP Workshop for Supervisors of Advanced Trainees

1

2

YEAR(S) FOR WHICH ACCREDITATION IS SOUGHT (circle) 2016, 2017, 2018, 2019, 2020

NO. OF INPATIENTS BEDS: QUALITY ASSURANCE PROG?(circle) YES/NO

ON CALL FOR EMERGENCIES DURING NORMAL WORKING HOURS? (circle) YES/NO

ON CALL FOR EMERGENCIES AFTER HOURS? (circle) YES/NO

NO. OF AMBULATORY CARE (OUTPATIENTS) CLINICS/WEEK:

AVERAGE NO. OF INPATIENT CONSULTATIONS/WEEK :

NO. OF PART-TIME NEUROLOGISTS IN THE DEPARTMENT:

NO. OF FULL-TIME NEUROLOGISTS IN THE DEPARTMENT:

NO. OF EEGs/WEEK NO. OF EMGs/WEEK NO. OF EPs/WEEK

YES/NO CT SCAN (*)

YES/NO ANGIOGRAPHY: (*)

YES/NO READY ACCESS TO MRI: (*)

YES/NO WEEKLY NEURORADIOLOGY REVIEW MEETINGS: (*)

YES/NO MONTHLY NEUROPATHOLOGY TEACHING SESSION: (*)

YES/NO NEUROSURGERY SERVICE: (*)

YES/NO PSYCHIATRY SERVICE: (*)

YES/NO ONE SUPERVISED NEUROREHABILITATION SESSION/WEEK FOR 6 MONTHS:

(*)

(*) If off-site please nominate facility

BRAIN SCHOOL:

Quarantined Time for trainee participation in National Brain School

Location of video-conferencing facilities at hospital: Contact details of technical support person:

Hospital or Area Health Authority will allow access to these facilities at no cost to trainee: Yes/No

OTHER SUB-SPECIALTY TRAINING AVAILABLE? YES/NO

IF YES, NOMINATE SPECIALTIES:

SIGNED: NAME:

DATE: POSITION:

Accredited Yes No Date.....

Comment: Accredited by:

..... (Please print name)