



AUSTRALASIAN COLLEGE
FOR EMERGENCY MEDICINE

Reference No: Form NSC223
Last Revised: 12/06/18
Version No: 1.2

EMERGENCY MEDICINE CERTIFICATE ENROLMENT FORM

This form is to be used for enrolment in the Emergency Medicine Certificate at the Australasian College for Emergency Medicine (ACEM).

Any enquiries should be directed to ACEM, via email EMCD@acem.org.au or phone +61 3 9320 0444.

SECTION A: Eligibility for Enrolment

1. Have you previously been registered with ACEM? NO ☐ **Go to question 2**
YES ☐ **ACEM Membership Number:**



Trainees who wish to enrol in the Certificate program must first terminate their participation on the FACEM Training program as they cannot be enrolled in both programs at the same time.

2. Do you have registration with either the Australian Health Practitioner Regulation Agency (AHPRA) or the Medical Council of New Zealand (MCNZ)?

YES ☐

Provide your registration number for the relevant medical board
Note: Limited or provisional registration is acceptable

AHPRA

MCNZ

NO ☐



If you are not registered with one of these boards, you are not eligible to enrol.

3. Are you in PGY 2 or above with a minimum of 10 weeks experience (at 1.0 Full Time Equivalent (FTE)) in an Emergency Department? YES ☐ **Go to question 4**
NO ☐



You are not yet eligible to enrol.

4. Please detail a minimum of 10 weeks experience in an emergency department.

ED start date	ED end date	Hospital (city and country)	Hrs/ week	Supervisor name	Supervisor signature
24/2/16	4/11/16	St Vincent's Melbourne, Aus	40	John Smith	John Smith



If your supervisor is unavailable to sign above, please attach a term report or written statement from the hospital as evidence of your experience.

5. Will you be working at least 0.5 FTE (minimum of 19 hours per week) in an emergency department for the duration of the program?
- YES ☐ **Go to question 6**
- NO ☐



You are not eligible to enrol as you are not working at least 19 hours per week in an emergency department.

6. Please detail your prospective 6 months FTE emergency department time towards the EMC.

Note 1: Training may be undertaken in blocks of not less than 6 FTE weeks.

Note 2: EMC trainees are required to complete the EMC within a 2 year timeframe.

ED start date	ED end date	Hospital	Hrs/ week	Position
Current	1/12/17	St Vincent's Melbourne	40	RMO

SECTION B: Applicant's Personal Details

Please provide your full name, date of birth and contact details.

Title		
DR <input type="checkbox"/>	MR <input type="checkbox"/>	MRS <input type="checkbox"/>
MISS <input type="checkbox"/>	MS <input type="checkbox"/>	OTHER <input type="text"/>
Family name		First name
<input type="text"/>		<input type="text"/>
Middle name(s)		Preferred name
<input type="text"/>		<input type="text"/>
Date of birth (DD/MM/YY) <input type="text"/>		
Sex		
Male <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate/Intersex/Unspecified <input type="checkbox"/>		
Residential address (e.g. Unit 1A, 14 City Road)		
<input type="text"/>		
Suburb/Town		
<input type="text"/>		
State/Territory/International province	Postcode/ZIP	Country (if outside Australia)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Preferred Phone	Alternate Phone	
<input type="text"/>	<input type="text"/>	
Email Address		
<input type="text"/>		

Postal address (if different to your residential address).

Postal address (e.g. Level 3, 14 City Road or PO Box 12)	
<input type="text"/>	
<input type="text"/>	
Suburb/Town	State/Territory/International province
<input type="text"/>	<input type="text"/>
Postcode/ZIP	Country (if outside Australia)
<input type="text"/>	<input type="text"/>

SECTION C: Educational Details

Basic medical degree

Year conferred

University

If qualification obtained outside Australia or New Zealand, specify *city and country* also

Are you a Fellow of a medical college(s)? If yes, please list below.

Are you a current trainee in a specialist training program? If yes, please list below.

SECTION D: Indigenous Status

The Australasian College for Emergency Medicine, in association with the Council of Presidents of Medical Colleges, is collecting workforce data to ascertain the numbers of indigenous Fellows and trainees working in Australia and New Zealand.

By answering these questions, you are contributing to the collection of valuable information which will assist the College to design and implement an effective training program including designing relevant and culturally appropriate learning material.

The following questions are voluntary.

Are you of Aboriginal and/or Torres Strait Islander origin?

For persons of both Aboriginal and Torres Strait Islander origin, mark both 'YES' boxes.

NO ☐ YES, Aboriginal ☐ YES, Torres Strait Islander ☐

Do you identify as Māori?

NO ☐ YES ☐

SECTION E: Supervisor Details

This section must be completed and signed by your Primary EMC Supervisor.

Primary EMC Supervisor Name

Hospital/s where trainee will be supervised

Preferred Phone

Email

I confirm that I am an approved EMCD supervisor (FACEM or Diplomate who has completed the Clinical Teaching Course) and I have agreed to supervise the applicant for the Emergency Medicine Certificate.

Signature

Date

SECTION F: Declaration by Applicant

I hereby apply for enrolment in the Emergency Medicine Certificate course of the Australasian College for Emergency Medicine. I acknowledge that I have read and understood the information provided on this enrolment form and in [Regulation D Non-Specialist Training Programs](#).

I declare that the information provided on this enrolment form is accurate and complete to the best of my knowledge.

Signature

Date

SECTION G: How did you hear about us?

How did you hear about the EMC program?

☐ Colleague

☐ Supervisor

☐ Conference (please specify) _____

☐ Other (please specify) _____

SECTION H: Payment Details

Select the enrolment fee applicable to you

Australia	AUD \$2,409.00	<input type="checkbox"/>
New Zealand	AUD \$2,190.00	<input type="checkbox"/>

Payment Authorisation

Select the appropriate payment method

☐ **Cheque or Money Order** (Australia)

☐ **Bank Draft in AUD\$** (New Zealand)

☐ **VISA**

☐ **MasterCard**

☐ **American Express**

Credit card number

Expiry date

Amount payable AUD\$

Credit card orders:

I authorise ACEM to charge my credit card for the enrolment fee as stated above.

.....
Cardholder signature

.....
Cardholder name (block letters)

.....
Date

Please send the completed enrolment form, along with any attachments to:



ACEM
34 Jeffcott Street
West Melbourne Vic 3003
Australia

Email: EMCD@acem.org.au

Fax: (03) 9320 0400