



**College of Intensive Care Medicine
of Australia and New Zealand**

ABN: 16 134 292 103

APPLICATION TO PRESENT FOR OTS PERFORMANCE ASSESSMENT

Application category: **General Fellowship** **Paediatric Fellowship**

SURNAME: (BLOCK LETTERS).....

OTHER NAMES: (BLOCK LETTERS).....

ADDRESS (to which Examination Notices can be sent):.....

EMAIL ADDRESS:..... **TELEPHONE NO:**.....

PLEASE ENSURE YOU HAVE PROVIDED A CURRENT EMAIL ADDRESS AS IMPORTANT EXAMINATION NOTICES WILL BE FORWARDED VIA EMAIL.

CITY IN WHICH CANDIDATE WISHES TO SIT:

WRITTEN SECTION:..... DATE:.....

ORAL SECTION:.....

**THIS APPLICATION WILL NOT BE
ACCEPTED WITHOUT PASSPORT
QUALITY PHOTOGRAPHS ATTACHED
TO THIS FORM.**

NOTE REGULATION 5.15.2
Application to present for the Fellowship Examination must be made on the approved form and must include the required documents and the prescribed fee. The completed application must be received by the Co-ordinator, Training and Exams at least 56 days before the commencement date of the Written Examination.

..... PRINT NAME SIGNATURE

..... PRINT NAME SIGNATURE

SENSOR APPROVED:..... DATE..... (OFFICE USE ONLY)

IMPORTANT NOTICE

This application must be completed and returned to the Training and Examinations Coordinator, College of Intensive Care Medicine, Suite 101, 168 Greville Street PRAHRAN VIC 3181, together with the full amount of the fee. Cheques or drafts to be made payable to the College of Intensive Care Medicine and crossed "Not Negotiable Bank Account Payee Only".
CREDIT CARD FACILITIES - See over

NAME & DATE OF PRIMARY OR PART 1 EXAMINATION COMPLETED:

.....

DETAILS OF CURRENT TRAINING POSITION:

(If you are **not** undertaking Intensive Care training please provide the details of a suitable supervisor or ICU mentor that is able to receive feedback on your behalf.)

Discipline.....

Hospital.....

Supervisor of Training:

Contact Phone number:

SUPPORTING DOCUMENTATION

PLEASE ENSURE THAT YOUR ICU HOT CASE ASSESSMENT FORM IS ATTACHED TO THIS APPLICATION. IF YOU ARE RE-SITTING THE EXAM YOU ARE REQUIRED TO SUBMIT FOUR NEW HOT CASES. IF YOU HAVE **NOT** PREVIOUSLY FORWARDED DOCUMENTARY EVIDENCE OF TRAINING APPROVED BY THE COLLEGE OR EVIDENCE OF HAVING PASSED A SUITABLE PRIMARY OR RECIPROCAL EXAMINATION, PLEASE INCLUDE WITH THIS APPLICATION.

METHOD OF PAYMENT

<input type="checkbox"/>	Bank Draft/Cheque made payable to "College of Intensive Care Medicine"	CREDIT CARD DETAILS:																				
		<input type="checkbox"/> Mastercard <input type="checkbox"/> Visa																				
		Credit Card number: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				
<input type="checkbox"/>	Credit Card (please complete details)	CVV Number: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				
		The Card Verification Value (CVV*) is an extra code printed on your debit or credit card. CVV for Visa and MasterCard is the final three digits of the number printed on the signature strip on the back of your card.																				
		Expiry Date: /.....																				
		Name on Card:																				
		Amount Paid:																				
		Signature:																				

PLEASE NOTE - REGULATION 5.16.3

A Candidate whose entry has been accepted and who withdraws from the examination on or after the date on which entries close, or who fails to attend at the examination, may be required to forfeit the examination fee.

I certify that

- (i) I am free of chemical dependency
- (ii) I have no illness which would preclude the safe practice of intensive care

I acknowledge that any drug or chemical dependence by me or condition which precludes the safe practice of intensive care may result in the suspension or termination of my training at any time and prevent my admission to Fellowship. I also give consent for information regarding my performance in the examination to be provided to my Supervisor or Mentor:

Signature: Date: