



Vocational scope application

VOC3

For doctors who **do not** hold the prescribed New Zealand or Australian postgraduate qualification ie Fellowship

September
2011

Application to determine the requirements you need to complete to be granted a vocational scope of practice

IMPORTANT INFORMATION

- You should only complete this form if you hold a **postgraduate medical qualification(s)** from a country outside of New Zealand and Australia.
- All sections of this form **must** be completed, with fees paid and supporting documents enclosed, before submitting your application to Council. Please ensure you submit your application at one time.
- Processing may take 4-6 months before a final decision is given, from the time that a complete application is received. It will take longer if your application is incomplete.
- Please submit this application form with the supporting documentation outlined in the VOC3-B form "Documents required for vocational scope of practice – For doctors that do not hold the prescribed New Zealand or Australia Fellowship qualification".
- You must complete the form and tick relevant boxes.

SECTION 1 – APPLICATION AND PERSONAL IDENTIFICATION DETAILS

Vocational scope:

(in which registration is requested)

Names(s) Show given names on your passport or birth certificate, unless your name has been legally changed (eg: by deed poll)

Family name(s):

First name(s):

Other names (unmarried name, name change, alias etc):

If names differ from those on your medical qualifications, passport and documents, please tick box to show reason:

marriage

deed poll

common use

other (explain)

Identification

This information may be disclosed to overseas registration authorities to verify your identity

Date of Birth

day / month / year

Male

Female

Practising Intentions

To be completed so Council can advise you on appropriate registration options

How long do you intend to work in New Zealand? Eg permanently / 12 months / temporarily

SECTION 2 – CONTACT DETAILS

All written communications will be sent to your postal address. Please print clearly.

Postal address:

Residential address:

Work address:

Telephone (home):

Telephone (work):

Mobile:

Email address:

Facsimile:

Other: (explain)

SECTION 3 – QUALIFICATIONS (awarded or conferred upon completion of training)

Name of primary medical qualification:		Abbreviation:
Date Awarded:	Awarding University / College:	Country:
Do you hold a primary medical degree from a university medical school listed in the AVICENNA directory of medical schools? <input type="checkbox"/> Yes (evidence is needed if University listed does not match qualification submitted) <input type="checkbox"/> No		

Name of postgraduate medical qualification:		Abbreviation:
Date Awarded:	Awarding University / College:	Country:

Name of other postgraduate medical qualification / completion certificate eg CCT/ recertification certificate:		
Date Awarded:	Awarding University / College	Country

SECTION 4– TRAINING PROGRAMME (Please include comprehensive information as noted in the VOC3-B form)

General questions	
What was the duration of your training programme?	_____ years
Did you complete a national or regional /state training programme?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you complete a structured and independently accredited training programme where performance is assessed and qualification awarded? (This means a programme where you are supervised, and feedback given by more than one person).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Basic medical training and/or experience (1 st and 2 nd years out of medical school until starting your vocational training).					
Dates (month & year) (from – to)	Role	Branch of medicine	Hospital / practice	City & Country	Accredited training position?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Vocational or Advanced Specialist Training					
Please tick <input checked="" type="checkbox"/> in the last column, whether the role and dates worked, are accredited training positions.					
Dates (month & year) (from – to)	Role	Branch of Medicine	Hospital / practice	City & Country	Accredited training position?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation of gaps of 3 months or more in your basic and advanced training	

Summary of assessment(s) undertaken during advanced training

If relevant, please tick which type you undertook and when.

- **Oral / Viva** (ie examination conducted by spoken communication)
- **Clinical examinations** (eg multidisciplinary assessment where you would undertake clinical tasks at your place of employment on patients; role playing patients or examiners)
- **Multi-choice questions** (ie written format, a scenario is presented and you would tick or select a number of options from which you would have selected the best answer)
- **Written examination** (short or long answer scenarios presented and you would provide your response)

You will be required to provide more details than in this form. Please refer to VOC3-B form.

Examination	Type of examination				
• Entry (start)	<input type="checkbox"/> Clinical	<input type="checkbox"/> Written	<input type="checkbox"/> Oral / Viva	<input type="checkbox"/> MCQ	<input type="checkbox"/> Other (provide explanation)
• During (middle)	<input type="checkbox"/> Clinical	<input type="checkbox"/> Written	<input type="checkbox"/> Oral / Viva	<input type="checkbox"/> MCQ	<input type="checkbox"/> Other (provide explanation)
• Exit (end)	<input type="checkbox"/> Clinical	<input type="checkbox"/> Written	<input type="checkbox"/> Oral / Viva	<input type="checkbox"/> MCQ	<input type="checkbox"/> Other (provide explanation)
• Other:	<input type="checkbox"/> Clinical	<input type="checkbox"/> Written	<input type="checkbox"/> Oral / Via	<input type="checkbox"/> MCQ	<input type="checkbox"/> Other (provide explanation)

Workplace based assessment: (Please give details)

Other type of assessment:

SECTION 5 – EXPERIENCE – AFTER OBTAINING YOUR VOCATIONAL QUALIFICATION(S)

Experience (since you were awarded your postgraduate qualification)

Dates (month & year) (from – to)	Role	Branch of Medicine	Hospital / practice	City & Country

Academic practice/experience (eg working at a University as a Fellow)

Dates (month & year) (from – to)	Role	Branch of medicine	Hospital / practice	City & Country

Explanation of gaps of 3 months or more in your employment experience

Registration or licensing history

Country/State	Date registered/licensed (from-to)	Current status

Continuing Professional Development

Are you required by a regulatory / registration authority to participate in any continuing professional development activities? (Please note that you will need to include a comprehensive list / details of CPD activities with your application. Refer to VOC3-B form for details)

Yes No

SECTION 6 – NOMINATION OF PROFESSIONAL REFEREES

- Please nominate 3 referees who are registered specialists who work in the vocational branch of medicine in which you are making your application. You must have worked in a clinical setting with them for at least **6 months during the last 3 years**.
- At least 1 referee must be from your current place of employment.
- You may be asked to provide the name of another referee if your nominated referee is not suitable, and the processing of your application will be delayed.
- Please notify your referees that Council will contact them to obtain references, and ask them to respond within 20 working days to avoid delays in processing your application.

Referee 1: Full name

(from current employment)

Area of medicine:

Registration number:

Country where registered:

Contact Address:

Organisation where you worked together?

Professional relationship to you, eg senior colleague:

Phone:

Email:

Is English your referee's native and first language? Yes No

Period worked with referee:

From:

month / year

To:

month / year

Referee 2: Full name

Area of medicine:

Registration number:

Country where registered:

Contact address:

Organisation where you worked together?

Professional relationship to you, eg senior colleague:

Phone:

Email:

Is English your referee's native and first language? Yes No

Period worked with referee:

From:

month / year

To:

month / year

Referee 3: Full name

Area of medicine:

Registration number:

Country where registered:

Contact address:

Organisation where you worked together?

Professional relationship to you, eg senior colleague:

Phone:

Email:

Is English your referee's native and first language? Yes No

Period worked with referee:

From:

month / year

To:

month / year

SECTION 7 – FITNESS FOR REGISTRATION YOU MUST COMPLETE BY TICKING YES OR NO TO EACH QUESTION.

This information is required under section 16 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) to ensure that no person is registered as a doctor in New Zealand whose previous or current competence for fitness to practise may pose a risk to public health and safety.

1. English language

Do you meet Council's English language requirements for registration? Yes No

You must tick at least one criterion from the list below to meet Council's requirements, and provide evidence where required.

a) Do you have a primary medical qualification from a NZ medical school; or Yes

b) Is English your first language and do you have a primary medical qualification from Australia, the UK, the Republic of Ireland, the USA, Canada or a South African medical school where English is the sole language of instruction (evidence required); or Yes

c) Have you completed at least 24 months full time equivalent of a postgraduate qualification at the University of Otago or the University of Auckland; AND
Have you provided references from two professors from the University who are registered as doctors in NZ and who speak English as a first language (evidence required); or Yes

d) Have you provided evidence of continuous work as a registered medical practitioner in an institution where English was the first and prime language for a period of at least 2 years within the last 5 years prior to application; AND
Have you provided the names and contact details of two referees who are suitable senior medical practitioners who speak English as a first language and can attest to your ability to communicate effectively in English in a clinical setting (evidence required); or Yes

e) Have you previously held registration with the Council, which was granted after 18 September 2004 and was not cancelled as a result of an order of the Health Practitioners Disciplinary Tribunal or a direction by the Council under section 146 or 147 of the HPCAA; AND
Have you provided the names and contact details of at least two referees who are suitable senior medical practitioners registered in New Zealand, and who can attest to your ability to communicate effectively in English in a clinical setting (evidence required); or Yes

f) Did you sit the Academic Module of IELTS within the last two years and did you achieve a minimum of 7.0 in the components of Reading and Writing and a minimum of 7.5 in the components of Listening and Speaking (evidence required)? Yes

2. Communication / cultural competence skills

a) Have you completed any communication skills courses or training? Yes No
If YES, further details are to be included in your application.

b) Have you completed any courses on interaction with diverse groups of people (cultural, religious etc) Yes No
If YES, further details are to be included in your application.

3. Mental and Physical Condition

Have you ever been or are you now affected by any mental or physical condition or impairment with the capacity to affect your ability to perform the functions required for the practice of medicine? These include neurological, psychiatric or addictive (drug or alcohol) conditions, including physical deterioration due to injury, disease or degeneration. Yes No

(If 'YES', please provide full details of condition(s), duration of any treatment, name and contact details of treating practitioner, involvement of university/medical school.)

If 'YES', can the Council's Registrar contact your treating practitioner(s) for further information? Yes No
If 'No' your application for registration may be delayed while advice is obtained from Council's Health Committee.

4. Conduct / character -If you answer YES to any questions below, please provide full details on a separate sheet.

Convictions		
(i)	Has any court in New Zealand or elsewhere convicted you of any offence punishable by imprisonment of 3 months or longer? If yes, please attach a certified copy of your conviction notice(s).	Yes <input type="checkbox"/> No <input type="checkbox"/>
Professional conduct		
(i)	Did you, for any reason, have any time when you were not participating in your medical degree programme for more than 2 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii)	Are you now (or have you ever been) the subject of university disciplinary proceedings?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii)	Are you currently (or have you ever been) the subject of an investigation in New Zealand or in another country, in respect of any matter that may be the subject of professional disciplinary proceedings?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv)	Are you currently (or have you ever been) the subject of civil proceedings related to competence or negligence issues?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v)	Have you ever been refused medical indemnity insurance cover or had your premiums raised because of professional conduct, competence or negligence related claims?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi)	Have you ever breached any code of ethics relating to boundary issues regarding patient relationships?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vii)	Are you currently (or have you ever been) the subject of an order of any of the following:	
	• New Zealand Health Practitioners Disciplinary Tribunal?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	• Overseas medical disciplinary tribunal or similar tribunal?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	• Medical Council of New Zealand or similar registration authority overseas?	Yes <input type="checkbox"/> No <input type="checkbox"/>

5. Professional competence- If you answer YES to any questions below, please provide full details on a separate sheet.

a)	Are you currently (or have you ever been) the subject of a competence enquiry with a registration / licensing authority or employer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b)	Have you ever had your employment as a doctor terminated on the grounds of poor performance or had your practising privileges restricted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c)	Have you ever had your medical licence, certificate of registration or permit to practise medicine suspended, restricted or revoked?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d)	Have you ever voluntarily surrendered your medical licence, certificate or registration or permit to practise medicine for any reason other than avoidance of a renewal fee?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e)	Have you ever had conditions imposed on your registration?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f)	Have you ever had conditions imposed on your licence/practising certificate or equivalent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
g)	Have you ever been denied registration, or been refused a licence/practising certificate or equivalent?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 8 – EMPLOYMENT

Have you been appointed to a position as a medical practitioner in New Zealand?	
<input type="checkbox"/> Yes (please provide details below, and attach a letter of appointment) <input type="checkbox"/> No – please go to Section 10	
Employer	
Place of work	
HR contact person	
Level of position	
Proposed supervisor	
Proposed length of employment	From / / to / / day month year day month year

SECTION 9 – DECLARATION - PLEASE READ CAREFULLY BEFORE SIGNING

- I hereby certify that I am the person who is applying for registration as a medical practitioner in New Zealand, that I am the person named in the above qualifications, and that the information I have given above is true and correct.
- I understand that the information that I have provided is to be used by Council and its agents for the purposes of considering my application, and may be disclosed to agents of the Council for these purposes.
- I understand that Council is authorised to obtain further information from me or any other person or organisation concerning this application under the Health Practitioners Competence Assurance Act 2003 (HPCAA) and consent to the collection of such information by the Council or its agents subject to Council notifying me of the person who will be contacted and of the questions that will be asked of them. I further understand that although the provision of any information by me is voluntary, refusal to provide any information may affect Council’s consideration of my application.
- I understand that I am entitled to access the information held by Council regarding this application by a request in writing and that I may request correction of any information which is not correct.
- I undertake to inform myself of my responsibilities as a registered medical practitioner in New Zealand and to abide by established codes of professional ethics or conduct and patients’ rights.
- I understand that Council will consider three requirements before I am registered, whether I hold the appropriate qualifications, training and experience; fit and competent for registration in the vocational scope that I have made an application.
- I understand that this is an application for assessment that takes approximately 6 months before I will know what I need to complete toward obtaining vocational registration.
- I understand that Council will review my application for completeness and at that time endeavour to manage my expectations by indicating whether there is any aspect of my application that **may** impact on the likelihood of success down this pathway.
- I understand that if I am successful in my initial application (VOC3) that I will be registered in a provisional vocational scope, to complete supervision and assessment requirements, before I can make a final application to be considered for a vocational scope.

Section 172 of the HPCAA, for your information.

Section 172 states that it is an offence for a person to make false or misleading declarations and representations in relation to any information that is relevant to Council, the Tribunal or a Professional Conduct Committee. A person may be liable on summary conviction to a fine not exceeding **NZ\$10,000**.

Applicant’s signature:

Date:

SECTION 10 – FEES payable on application (fees listed are GST inclusive)

- Application fee: **NZ\$434.45 - Non-refundable**
 - This is required for Council staff to process your application.
- Preliminary advice fee: **NZ\$750.95- Refundable if preliminary advice not required**
 - If you are resident overseas (outside of NZ) when you submit your application, you can request an initial paper based assessment of qualifications, training and experience by the branch advisory body (BAB) (ie specialist College). If successful in your application, you will need to attend an interview.
- Interview fee **NZ\$2719.75- Non refundable as interview is required for all scopes (except for scope of general practice)**
 - For a final assessment of your qualifications, training and experience, you would need to attend an interview with the BAB. The interview fee will be payable before the documents are sent to the BAB.

Credit Card type

MasterCard

Visa

Cheque enclosed

Card number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Expiry date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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Name on card

Cardholder’s signature

Date

dd / mm / yy