



## Collegial relationship agreement

**PLEASE READ THE FOLLOWING. THEY CONTAIN IMPORTANT INFORMATION.**

### Collegial relationship agreement

The purpose of this agreement is to set out the terms of reference for the collegial relationship and clarify the objectives and responsibilities of each colleague.

#### Objective

**The objective of the relationship is to** ensure that the doctor's professional development plan (PDP) and Continuing Professional Development (CPD) activities are appropriate for the area of medicine they are working in.

#### Responsibilities of the doctor:

The responsibilities of the doctor are to:

- organise meetings with their collegial relationship provider, lasting one hour, initially six times a year, and at least four times a year in subsequent years
- provide materials for discussion and review (for example multisource feedback and audit reports)
- make a record of all collegial relationship meetings ([CPD2](#))
- record all details of CPD activities completed (Forms [CPD3](#), [CPD4](#), [CPD5](#), [CPD6](#))
- update their PDP following collegial relationship meetings as appropriate.

#### Responsibilities of the collegial relationship provider:

The responsibilities of the collegial relationship provider are to:

- be available for meetings
- ensure the doctor makes an adequate record of the meetings ([CPD2](#))
- review feedback and other educational and quality assurance material and support the doctor to reflect on their PDP utilising feedback to inform their learning needs
- take appropriate action if concerns arise about the doctor's fitness to practise.

#### Liability

The collegial relationship provider is neither responsible nor liable for the doctor's decisions unless they have been directly involved in the care of their patients. In this case any investigation would include an investigation of the collegial relationship provider's level of involvement.

**PLEASE COMPLETE THE FOLLOWING TO INDICATE THAT BOTH PARTIES HAVE READ AND AGREED TO THE RESPONSIBILITIES ABOVE.**

### Details of collegial relationship

**Doctor (please fully complete this section or will it not be processed)**

<b>Name:</b>		<b>MCNZ Registration Number:</b>	
<b>Signature:</b>			
<b>Period agreed on - From:</b>		<b>To:</b>	
* This will need to be assessed on an annual basis when you renew your practice certificate			
<b>Employment level (e.g. HO)</b>		<b>Branch of medicine:</b>	
<b>Workplace:</b>			

### Collegial relationship provider within the same or similar vocational scope of practice to that the doctor is working in

<b>Name:</b>		<b>Date:</b>	
<b>Signature:</b>		<b>MCNZ Registration Number:</b>	

Please take a copy for your record and email to [pc@mcnz.org.nz](mailto:pc@mcnz.org.nz)