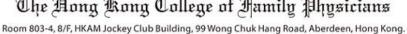


## 香港家庭醫學學院 The Yong Tong College of Family Physicians





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## Application Form for Certification of Completion of Higher Training in Family Medicine

Name of trainee:	Dr	
Starting date of training:		(dd/mm/yy)
Completion date of training:		(dd/mm/yy)
I would like to apply for comple	etion of Two-year higher training.	
My training rotation:		
Period (mm/yy- mm/yy)	Name of training unit	Clinical supervisor
Enclosed are the original copy higher training for your reference	of my training logbook and the chec	cklist for completion of
Signature:	Date	

## To: Chairman of Higher Training Subcommittee, BVTS of HKCFP

## **Checklist for Completion of Higher Training**

Trainee: Dr		
Clinical Supervisor: Dr		
Checking items and content (Tick as appropriate)	Trainee Section	Verification by BVTS
Records of Practice Visits w/ Feedback (6 months intervals)  Date of 1 <sup>st</sup> visit:		
Date of 2 <sup>nd</sup> visit:		
Date of 3 <sup>rd</sup> visit:		
Date of 4 <sup>th</sup> visit:		
Consultation Skill Review LAP (6 months intervals)		
Supervisor Feedback /Assessment (annually)		
Self-Directed Education & Critical Appraisal Exercises (> 40 hrs / 6 months)	Total: hours	
Pre-Approved Structured Educational Program (Confirmation by course organizer) (>160 hours, >80 sessions, >1	5 hours per module)	
1. Principles and Concepts of Working with Families	hours	
2. Family Interview and Counseling	hours	
3. Difficult Consultations and Ethical Dilemmas	hours	
4. Clinical Audit and Research in Family Medicine	hours	
5. Critical Appraisal	hours	
6. Preventive Care and Patients with Special Needs	hours	
7. Health Economics and Advanced Practice Management	hours	
8. Teaching and Training	hours	
Total :	hours	
Record of Sit in / Videotaped Sessions (6 monthly) Submit at least 3 videotaped consultations to BVTS		
Learning plans / Record of Supervisor Feedback (6 monthly)		
Learning portfolio kept (6 monthly)		
Content checklist completed and signed		
2 weekly patient profile completed		
Attendance of Hong Kong Primary Care Conference (once)		
*all requirements above need to be completed before the end of tra	iining	
Signature of trainee	Date	
For official use only	<u>'</u>	
Other comments / Recommendation		
The trained is / is not recommended for a small-time of two services.	high or training	
The trainee is / is not recommended for completion of two years of	nigner training	
The report is completed by Dr	(Block letter)	
Signature: Date	e	