PEPA Program of Experience in the Palliative Approach

Funded by the Australian Government Department of Health

APPLICATION FORM for PEPA 2017 - 2020

Western Australia

Instructions

Please complete the relevant sections of this application form and return to your PEPA Manager:

PEPA MANAGER WA
Cancer Council WA
Palliative & Supportive Care Education Team
Level 1, 420 Bagot Rd
SUBIACO WA 6008
Email: Pepa@cancerwa.asn.au Ph.: 08 9382 9372 Fax: 08 9212 4334

Section A: Privacy & Confidentiality – ALL APPLICANTS TO COMPLETE

All information provided by you in this application will be kept private and confidential. This information will only be used for the purposes of:

- Assessing your eligibility for the program
- Allocation of clinical placements, follow-up and post-placement support
- Program evaluation
- Confirmation of your qualifications and current registration /authority to practice

For these purposes, your details and program report may be forwarded to the QUT PEPA National Team and the Palliative & Supportive Care Education Team for post placement workshops.

Please tick

□ **I understand and agree to the information I have provided to be used for the above purposes.**

□ **I consent to my name and contact details being forwarded to the relevant person for post-placement support activities.**

Section B: Applicants Details – ALL APPLICANTS TO COMPLETE

Title □Mr □Mrs □Ms □Dr □Other _____

Surname: _____

Given Name(s): _____

Postal Address: _____

_____

Daytime Phone: _____

Mobile Phone: _____

Email Address: _____

Emergency Contact _____ Name of Next of Kin / Emergency Contact _____ Phone Number of Contact

Do you have a disability or impairment that may require assistance or aids during placement? If so, please specify what might be needed: _____

Section C: Australian Aboriginal and/or Torres Strait Islander and/or CALD status

Q1. Are you of Aboriginal or Torres Strait Islander origin? (Please answer yes only if you are a person of Aboriginal and/or Torres Strait Islander descent, identify as an Aboriginal and/or Torres Strait Islander and are accepted as such by the community in which you live.)

□ Yes □ No

Q2. In which country were you born?

□Australia □New Zealand □England □Italy □Vietnam □India □Scotland □Other, please specify:_____

Q3. Do you speak a language other than English *at home*?

□No, English only □Yes, Italian □Yes, Greek □Yes, Cantonese □Yes, Arabic □Yes, Mandarin □Yes, Vietnamese □Yes, other, please specify:_____

Section D: Eligibility Criteria – ALL APPLICANTS TO COMPLETE

Q1. Are you currently employed (including self employed) in a health, aged or community care service that provides services for people with chronic and/or life-limiting illness?

□ Yes □ No (You cannot proceed any further if you tick this box)

Q2. Is your registration / practising certificate current?

□ Yes - you must provide details in the space provided and attach evidence – then go to Question 4

□ No (You cannot proceed any further if you tick this box)

□ Not Applicable (for non-regulated workers/carers) – go to Question 3

Registration Number	Registering Authority	Renewal Date

Q3. For non-regulated workers (i.e. workers from disciplines that are not regulated under the Australian Health Practitioner Regulation Agency), please specify your current position?

□ Aboriginal Health Worker
□ Indigenous Liaison Officer
□ Indigenous Community Worker
□ Migrant/Culturally & Linguistically Diverse Liaison Officer
□ Residential Aged Care Worker or Assistant in Nursing
□ Pastoral Care Worker/Chaplain
□ Paramedic/Ambulance officer
□ Speech Pathologist
□ Social Worker
□ Dietician
□ Bereavement Counsellor/Coordinator
□ Other, please specify _____

PEPA MANAGER USE ONLY

Form Version: v1

Date Received _____/_____/_____ Approved _____/_____/_____ PEPA Manager _____

Date Notified _____/_____/_____ Host Site _____ Placement Dates _____/_____/_____

Note: If you are seeking to undertake an interstate placement you are responsible for obtaining mutual recognition of registration to practice from the relevant state/territory regulatory authority prior to undertaking the placement.

Q4. Do you agree to have a 'criminal history check' prior to participating in the program as required by state/territory legislation and/or local institutional policies?

□ Yes □ No (You cannot proceed any further if you tick this box)

Q5. Have you obtained a *Working with Children* card or other appropriate authority as required by state/territory legislation and local institutional policies if undertaking a placement which may involve interactions with children?

□ Yes, please provide details below and attach evidence

□ No (If no, please discuss with PEPA Manager to determine whether this is required for your proposed placement)

Card number:_____ Expiry Date: _____

Q6. Are you self-employed?

□ Yes (Go to Section E of this application) □ No (Go to Section F of this application)

Section E: Self-employed Applicants Only

All self-employed applicants are required to provide their own insurance as per the *PEPA 2011-2014 Information Guide for Placements*.

Q1. Do you have current medical indemnity/ medical defence insurance that will cover you throughout your attendance at your PEPA supervised clinical placement/s?

□ Yes (please attach a "Certificate of Confirmation") □ No (You cannot proceed any further if you tick this box)

Q2. Do you have current Work Cover or Income Protection insurance that will cover you throughout your attendance at the PEPA supervised clinical placement/s?

□ Yes (please attach a "Certificate of Confirmation") □ No (You cannot proceed any further if you tick this box)

Q3. Do you currently have a Work Cover Claim?

□ Yes (go to question 4) □ No (Go to the Participant Declaration for this section)

Q4. Is a PEPA placement consistent with the current Work Cover Certificate of Capacity provided by your doctor?

□ Yes (please attach documentary evidence) □ No (You cannot proceed any further if you tick this box)

Participant Declaration: *I declare that my insurances (indicated above) are current and cover me throughout the period of my PEPA Placement, and a copy of current "Confirmation Certificate" for my medical indemnity insurance and Work Cover is attached. In signing this declaration I agree to comply with the responsibilities outlined in the PEPA Information and Application Kit.*

Please Note: You are required to attach a copy of the "Confirmation Certificate" for your medical indemnity insurance and Work Cover.

Place of Work: _____

Position Title: _____

Work Address: _____

_____

Work Email: _____

Work Phone: _____

_____ _____/_____/_____

Self-employed person's signature Date

Section F: Employed Applicants (not self-employed)

Place of Work: _____

Position Title: _____

Work Address: _____

_____

Work Email: _____

Work Phone: _____

Managers Declaration

Manager's Name: _____

Phone No: _____

Email: _____

Please Note: The following questions & declaration are to be completed by the applicant's manager (employer).

Q1. Will the applicant be covered by your organisation's professional indemnity insurance while undertaking a PEPA Placement?

□ Yes □ No (Applicant cannot proceed any further if you tick this box)

Q2. Will the applicant be covered by your organisation's Work Cover policy while undertaking a PEPA Placement?

□ Yes □ No (Applicant cannot proceed any further if you tick this box)

Q3. Does the applicant currently have a Work Cover claim?

□ Yes (Go to question 4) □ No (Go to question 5)

Q4. If yes, is the applicant's participation in PEPA consistent with the conditions of the Work Cover Certificate of Capacity provided by the applicant's doctor? (*Please note: If you have a Work Cover Claim you may not be able to participate in PEPA. Contact your local PEPA Manager for more information)*

□ Yes (Please attach documentary evidence of the doctor's approval for the applicant to participate)

□ No

Q5. Do you support the applicant to undertake a clinical placement and provide support for the learning that will be implemented on return to the workplace?

□ Yes □ No

Q6. Having read the PEPA 2015-2017 Information Guide, do you understand and agree to comply with all requirements for participation in the program?

□ Yes □ No

_____ _____/_____/_____

Manager's Signature Date

Section G: Placement Preferences – ALL APPLICANTS TO COMPLETE

Please Note: Placement preferences will be taken into account <u>where possible</u>.

□Local palliative care service	□ inpatient	□ community	□ hospital based consultancy
□Regional palliative care service	□ inpatient	□ community	□ hospital based consultancy
□Metropolitan palliative care service	□ inpatient	□ community	□ hospital based consultancy

Q1. What are your preferred dates / times for a placement?

_____

Q2. Are there any times that you would <u>not</u> be available for a placement?

_____

Q3. Are there any other constraints that would impact on your uptake of a placement?

_____

Section H: Applicant's Declaration - ALL APPLICANTS TO COMPLETE

If I am successful in securing a clinical placement, I understand that I may have access to information of a private and confidential nature, including information about the Host Site, its staff and patients. I understand that I have an obligation to maintain this confidentiality at all times and I declare that I will not disclose any information to any person, organisation or body, by any means (electronic, verbal, hard copy or other means).

I agree to comply with host site policies, including confidentiality, immunisation status requirements (where required) and workplace health and safety policies.

I declare that I do not have any current or pending misconduct proceedings or health conditions that would impact on my participation in this program. Also, I declare that if I am unwell during a placement I understand that it is my responsibility to raise this with my supervisor and cease work if either a patient(s) or my own health may be compromised.

In signing this application, I declare that the information provided by me in support of my application is true and accurate. Should I be successful, I agree to abide by the requirements of the program as outlined in the Information Guide. I agree to notify the PEPA Manager should any of the information provided in this application change before or during my participation in the program.

Applicant's Signature:_____ Date _____/_____/_____

Section I: Applicant's Checklist – ALL APPLICANTS TO COMPLETE

Please complete the following checklist to ensure you have attached all the necessary documentation.

□ Copy of your current professional registration or license to practice.

□ Copy of your current "Confirmation Certificate" for your medical indemnity insurance (applicable to self-employed applicants only).

□ Copy of your current *Working with Children* card if appropriate

Section J: Professional Development Points

Check the following boxes & include your membership number/s if registered with the following organisations:

□ Royal Australian College of General Practitioners (RACGP) – Membership Number _____

□ Australian College of Rural & Remote Medicine (ACRRM) – Membership Number _____

□ Royal College of Nursing Australia (RCNA) – Membership Number _____

□ Royal Australian College of Physicians – Fellowship Number _____

Section K: PEPA Promotions – ALL APPLICANTS TO COMPLETE

Which of the following promotions aided in your knowledge of and decision to apply for a PEPA placement? Tick all boxes that apply.

□ Personal contact from a PEPA staff member (phone, email, face to face)
□ Previous attendance at a PEPA workshop
□ PEPA booth/trade stand/satchel inserts at a conference, forum etc. Please specify _____
□ PEPA information brochures, posters, fliers or postcards
□ PEPA promotional DVD or YouTube clip
□ PEPA website
□ Article/advertisement in journal, newspaper or newsletter. Please specify _____
□ Specialist palliative care service (PEPA host site) promotions
□ Word of Mouth
□ Other. Please specify _____

Application Form for PEPA 2017 - 2020

APPLICANT'S NAME:_____

All applicants must complete this section. Please copy this page, and take with you to your clinical placement.

Q1. Please provide brief details of your current role in caring for people with life-limiting illness.

_____

_____

_____

_____

Q2. Why are you applying to undertake a PEPA placement?

_____

_____

_____

_____

Q3. List 3 key things you want to achieve during your PEPA placement?

_____

_____

_____

_____

Q4. How might you disseminate information about your experience to colleagues on return to your workplace?

_____

_____

_____

_____

Please Note:
On completion of your PEPA Placement, it is a requirement that all participants implement a quality improvement activity within their workplace, within 4 – 6 weeks.

Examples of activities that previous participants have undertaken include:

- *Development of new policy*
- *Development or improvement of patient assessment tools*
- *Organising in-service education related to palliative care*
- *Dissemination of morphine conversion tables, Therapeutic Guidelines for Palliative Care and other fact sheets*
- *Implementation of end of life care pathways*
- *Establishment of a Palliative Care Committee*
- *Implementation of multi-disciplinary team meetings*