ACADEMY OF FAMILY PHYSICIANS OF MALAYSIA

(Akademi Kedoktoran Keluarga Malaysia)

APPLICATION FORM FOR

PART II CONJOINT MAFP/FRACGP/icFRACGP EXAMINATION 2025

APPLICATION PROCEDURES:

1. Please write using **BLACK INK** or type in **BLACK TEXT COLOUR** only.
2. All applications must reach the secretariat of the AFPM on or before the closing date which is on the **01/07/2025. Late applications will NOT be accepted.**
3. Payment via online banking or telegraphic transfer should be made payable to the **"Academy of Family Physicians of Malaysia"; (Bank: Am Bank; Account Number: 001-201-010181-2).** Please forward the proof of payment via email to **accounts@afpm.org.my.** No cash payment will be accepted.
4. A non-refundable processing fee of **RM1,000.00** is incorporated into the Part II Conjoint MAFP/FRACGP/icFRACGP Examination fee. **The Part II Conjoint MAFP/FRACGP/icFRACGP Examination fee shall be paid in full by the candidate upon submission of this application form**. This application shall not be processed if no payment is made.
5. All sections of this application form must be completed and the declaration at the end of this application form must be signed by the candidate. Incomplete application form or inadequate supportive documents will be rejected.
6. Applicants are responsible for submitting the completed application form and all supportive documents using a link that will be provided to each applicant.
7. Applicants must not share their personalised link with any other parties.
8. Applicants must request the secured link (OneDrive) from the Exam Coordinator:

    a) Mr Mohd Aminuddin Sukor: amin@afpm.org.my

    For any IT-related issues, please email the IT Department:

    a) Mr Saufi Omar: saufiom@afpm.org.my

    b) Mr Afdal Diyaudin: afdal@afpm.org.my

    c) Ms Sharifah Hanim Ruslan: s_hanim@afpm.org.my

***PLEASE TAKE NOTE THAT FOR ATFM INTAKE 2019 ONWARDS, THE CONJOINT EXAMINATIONS HAVE BEEN RENAMED TO THE CONJOINT MAFP/ICFRACGP** EXAMINATIONS as ATFM intake 2019 onwards, the FRACGP award has been replaced with the icFRACGP award.*

*** ICFRACGP = INTERNATIONAL CONJOINT FRACGP*

NOTES:

AFPM Postgraduates Course Guideline and Policy Handbook 2025:

6.4 Eligibility Criteria for PART II Conjoint MAFP/ FRACGP/icFRACGP Examination ("Part II Examination")

6.4.1. For a trainee to be eligible to sit for the Part II Examination, such trainee must: -

a) have successfully completed the Part I Examination;

b) be a medical practitioner fully registered with the MMC and is practising in Malaysia;

c) be a member-in-benefit of the AFPM as defined in the AFPM's Constitution;

d) be a member-in-benefit of the RACGP;

e) be working full time in general practice/primary care or its approved equivalent for a period of not less than six (6) months continuously prior to the Part II Examination;

f) have a valid BLS certificate or ACLS certificate; and

g) provide a letter of good standing (LOGS) from clinical supervisor supporting the trainee's application.

6.4.2. For Part II Examination, trainees must take note that:

a) upon passing the Part I Examination, a trainee MUST attempt the immediate upcoming Part II examination as this will be considered as the FIRST attempt;

b) subject to item (c) below, a trainee has a maximum of THREE (3) consecutive attempts (including the first attempt) to pass the Part II Examination. A trainee shall be required to pay the Part II Examination registration fee for each attempt (please refer item 3 above on 'Fees & Refund Policy'). Failure to complete the Part II Examination within the maximum of three (3) consecutive attempts would mean that such trainee shall be required to re-enrol into the ATFM Programme and fulfil the criteria of Part I Examination and subsequently Part II Examination again;*

c) any deferment, withdrawal or absence by a trainee from any segment of the Part II Examination shall be deemed as a failed attempt of the whole of Part II Examination. The Board of Censors holds the discretion to offer a trainee with a "Special Deferment". A "Special Deferment" will only be granted one (1) time to a trainee that provides the Board of Censors with a valid reason together with written proof and such Special Deferment must be applied before the Part II Examination. A trainee may still have his/her remaining attempts to pass the Part II Examination if a Special Deferment is granted. Any decision made by the Board of Censors in consultation with the Chief Examiner is deemed final;

d) The Board of Censors may request additional information and documents or conduct an on-site visit to evaluate the application. Failure to respond to these requests within the specified timeframe will result in the rejection of the application; and

e) the Censor-in-Chief of the AFPM reserves the right to add, remove or make any changes to the eligibility criteria, policies, rules and regulations of the Part II Examination as and when considered necessary by AFPM, in consultation and with the agreement of the Chief Examiner and the Board of Censors. Trainees are advised to keep themselves updated by reading all the notifications and announcements in the AFPM website.

APPLICANT CHECK LIST:

☐	A. I have checked and read the eligibility criteria for the Part II of the Conjoint MAFP/FRACGP/icFRACGP Examination and confirm that I meet all the criteria therein.
☐	B. I have read and understood all the information in the 'AFPM Postgraduate Courses Guidelines and Policy Handbook', the "Conjoint MAFP/icFRACGP Examination Handbook", and all the rules, information, policies, and guidelines in AFPM's website.
☐	C. I have fully completed the application form (all sections) including Appendix A.
☐	D. One certified true copy of NRIC (for Malaysian) / certified true copy of the relevant pages of passport – i.e., identification pages (for non–Malaysian candidate).
☐	E. One certified true copy of current (2025) Annual Practicing Certificate (APC).
☐	F. Proof of active employment in general practice/primary care or its equivalent: Proof of employment: – A letter from the District Health Office (*Pejabat Kesihatan Daerah*) or Family Medicine Specialist (Head of Clinic) verifying the current posting at Klinik Kesihatan, or – Borang B/F if owns a clinic or is the person-in-charge (PIC) of a clinic, or – Private general practitioner who does not own a clinic kindly provide a letter from the employer. – For trainees who work in shifts, to provide work rosters (May and June). – Locum logs in the prescribed format provided by AFPM (if applicable). Letters must: – Be provided on the organisation's letterhead. – Include information on duration, days and hours worked and scope of job. – Be dated within one month of application date.

	– If you have changed practice within the last 6 months, you must submit verification letter from previous employer.
☐	G. Appendix A - Letter of Good Standing from clinical supervisor. - Ministry of Health, universities and Ministry of Defence trainees: form to be completed by the FMS in-charge of their clinic. - GP trainees: form to be completed by their appointed clinical supervisors.
☐	H. One valid Basic Life Support (BLS) Certificate (validity within 3 years) or Advanced Cardiac Life Support (ACLS) Certificate (validity within 5 years). Online certification without physical CPR training on mannequin is not accepted.
☐	I. One certified true copy of AFPM Membership Card or proof of current membership.
☐	J. One certified true copy of RACGP Membership Card or proof of current membership for July 25 – June 26.

Note: Where certified true copies of the relevant documents and certificates are required, such documents and certificates must be Signed and Stamped "Certified True Copy" by a fully registered medical practitioner. For Non-Malaysians, all documents and certificates must be in English or translated into English by an official translator.

SECTION I

A. PERSONAL PARTICULARS *(FILL USING **BLACK INK** PEN or TYPE IN **BLACK TEXT** COLOUR)*

Full Name: *(CAPITAL LETTERS)*			
Date of Birth:	**Age:**	**Gender:**	**Ethnicity:**
NRIC No / Passport No:		**Citizenship:**	
Email address:			
Home address:			
Postcode:	**District:**	**State:**	
Mobile telephone number:		**Home telephone number:**	
Year of full medical registration:		**Country of registration:**	
Full Medical Registration No:		**Current Annual Practicing Certificate No:**	
AFPM Membership No:		**RACGP Membership No:**	

B. PROFESSIONAL QUALIFICATION – BASIC MEDICAL DEGREE AND POSTGRADUATE QUALIFICATIONS

Date Obtained			Qualification	Name of College / University / Academy
dd	mm	yyyy		
dd	mm	yyyy		

dd	mm	yyyy		
dd	mm	yyyy		
dd	mm	yyyy		
dd	mm	yyyy		
dd	mm	yyyy		

C. WORK EXPERIENCES AFTER BASIC QUALIFICATIONS

Start date:			End date:			DETAILS ABOUT THE PRACTICE:
dd	mm	yyyy	dd	mm	yyyy	**Practice name:**
Duration:						
Position held: House Officer **Department/Specialty:** *Please list all internship rotations here.*						
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐ **Part time** ☐						**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐ **Part time** ☐						**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐ **Part time** ☐						**Department/Specialty:**

dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**
dd	mm	yyyy	dd	mm	yyyy	**Position:**
Duration:						**Practice name:**
Fulltime ☐			**Part time** ☐			**Department/Specialty:**

Number of years of experience in general practice / family medicine *(xxYears xxMonths)*:

D. GAPS IN EMPLOYMENT HISTORY. *(Kindly provide information on unemployment period or extended leave such as maternity leave, unpaid leave, or extended medical leave you had taken or planning to take from 28 March 2025 – 26 September 2025) Leave blank if not applicable.*

Start date			**End date**			**Explanation**
Day	**Month**	**Year**	**Day**	**Month**	**Year**	
dd	mm	yyyy	dd	mm	yyyy	
Duration :						
dd	mm	yyyy	dd	mm	yyyy	
Duration :						
dd	mm	yyyy	dd	mm	yyyy	
Duration :						
dd	mm	yyyy	dd	mm	yyyy	
Duration :						

E. RESEARCH AND PUBLICATIONS

Year of publication:	**Title:**

F. MEMBERSHIP OF PROFESSIONAL ORGANIZATIONS

G. MEMBERSHIP OF COMMUNITY SERVICE ORGANISATION.

(e. g. Red Crescent, St. John's Ambulance, Service Clubs, PTA, Befrienders, etc.)

H. LIST ANY SPECIAL SESSION OF COMMUNITY SERVICE THAT YOU DO.

(e.g., One session per week at factory, old folks' home, orphanage, family planning clinic, community hospital, nursing home, etc.)

I. QUALITY ASSURANCE ACTIVITIES

(List the activities such as practice accreditation, clinical audit, continuing professional development activities, etc that you have completed in the past 2 years. You may add a separate attachment if necessary)

SECTION II

A. PRACTICE DETAILS

Name and address of current and main workplace:		
Postcode:	**District:**	**State:**
Telephone No:	**(Mobile)**	**(Landline)**
Preferred Mailing Address (please circle):	**Home**	**Workplace**
Current job position:	Principal / Partner / Person-in-charge / Medical Officer / Locum / Others (specify):	
Private Healthcare Facility Act Clinic Registration No. (Private Practitioners only):		
Are you currently practicing in more than one practice? **(Please circle): Yes No**	**Number of practices:**	
Details on second practice (name and address):		
Postcode:	**District:**	**State:**
Telephone No:	**(Mobile)**	**(Landline)**
Job position:	Principal / Partner / Person-in-charge / Medical Officer / Locum / Others (specify):	
Private Healthcare Facility Act Clinic Registration No. (Private Practitioners only):		

Details on third practice (name and address):		
Postcode:	**District:**	**State:**
Telephone No:	**(Mobile)**	**(Landline)**
Job position:	Principal / Partner / Person-in-charge / Medical Officer / Locum / Others (specify):	
Private Healthcare Facility Act Clinic Registration No. (Private Practitioners only):		

What hours do you work each day? (eg. 8am-5pm, 2pm-8pm, 3pm-11pm etc.)

Practice name:

Mon	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*	*Sun*

Practice name:

Mon	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*	*Sun*

Practice name:

Mon	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*	*Sun*

How many days of leave do you take in a year (not counting weekends and public holidays)?

B. DESCRIPTION OF YOUR MAIN WORKPLACE

Name of your main practice:

PRACTICE LOCATION

The site of your practice: *Please select*

Stand-alone building / shop-lot / corporate building / factory in-house clinic / hospital-based / shopping complex / university campus / others (specify):

The area/zone of your practice: *Please circle*

Rural / District / Town / City / Others(specify):

For a solo practitioner: the distance from nearest working colleague is _____ km

Type of practice: *Please select and circle the appropriate option.*

☐ *Private sectors:* Solo / Partnership / Group / Franchise / Others (specify):

☐ *Public sectors:* Government Health Clinic (Klinik Kesihatan) / Staff Clinic / Ministry of Defence Primary Care Clinic / University Primary Care Clinic / Others (specify):

Any Family Medicine Specialist(s) in your practice: ☐ **Yes** ☐ **No**

If yes, specify visiting or resident:

List their names & qualifications:

Name:	**Qualifications:**	**Clinic Schedule:**

C. NATURE OF WORK

1. *Age groups seen at your clinic:*

2. *Any exclusion groups?*

3. *What is the average number of patients seen by you per week?*

4. *Clinic operating hours (if you are practicing in more than one clinic, please list the operating hours for each clinic).*

5. *The type of medical records used at your practice: Please select*

   ☐ *Electronic medical records*

   ☐ *Paper*

D. STAFF

List of staff/doctors at your main practice.

Job description / Position	Qualifications	Gender	Years of service/work experience
e.g. Registered nurse	*1 degree, 2 diploma*	*1 M, 2 F*	*5 -10*

E. SERVICES OFFERED AT YOUR PRACTICE

1. *Please list the drugs that are routinely prescribed for non-communicable diseases (such as for diabetes, asthma, hypertension, lipids lowering agents, antidepressants etc.) at your practice.*

2. *Do you have any arrangement for drugs that are not available at your clinic? If any, please elaborate on the arrangement with examples of drugs.*

3. *Please list the vaccines that are available at your practice.*

   Adults:

   Paediatrics:

4. *Please list health screening services offered at your practice.*

5. *Do you provide routine antenatal care services?* *Yes* ☐ *No* ☐

   If yes, what is the average number of cases seen per week?

6. *Please list family planning services offered at your practice.*

   What is the average number of cases seen per week?

7. *Please select the equipment and instruments available in your practice.*

   *Place an "**X**" at the appropriate options.*

☐	Adult weighing scale	☐	Microdermabrasion
☐	Ambu bag or equivalent	☐	Min/max thermometer
☐	Auroscope / Otoscope	☐	Nasal speculum
☐	Automated external defibrillator (AED)	☐	Nasopharyngoscope
☐	Blood pressure cuff: regular	☐	Oxygen supply
☐	Blood pressure cuff: large	☐	Paediatric weighing scale
☐	Blood pressure cuff: paediatrics	☐	Patella hammer
☐	Branula	☐	Peak flow meter
☐	Clinical waste disposal facility	☐	Proctoscope
☐	Colour vision chart	☐	Pulse oximeter

	Disposable syringes & needles, scalp vein set		Sharps disposal facility
	Doctor's bag for off-site consultation		Skin laser machine
	Doppler for fetal heart sound		Spacers, nebulizer
	Drip set with appropriate IV solutions		Special light source for ENT exam
	Drip stand		Sterilizer/Autoclave
	E chart for children		Stethoscope
	Ear syringing set		Stretcher
	ECG machine		Suction unit with catheters
	Endotracheal tubes		Thermometer
	Equipment for maintaining airway e.g. Guedel's		Torchlight
	Examination light		Tuning fork
	Fundoscope		Ultrasound scanner
	Instrument for testing sensation (touch, pain, etc)		Urinary catheter
	Instruments for circumcision		Vaccine refrigerator
	Instruments for other office/minor surgery		Vaginal examination set
	Instruments for toilet & suture		Visual acuity chart
	Laryngoscope		Wheel chair
	Magnifying glass		Wood's Lamp
	Measuring tape		X-ray machine
	Medical examination screen		X-ray view box (film illuminator)

8. *Please list all point-of-care/office tests (e.g. glucometer, urine dipstick etc.) that are available at your practice.*

9. Please list all medical/surgical procedures that you routinely perform at your practice.

F. PERSONAL WORKLOAD

The aim of this data collection is to provide a general view of your weekly caseload and case-mix.

*Record the total number (in digits) of all the patients who consulted you within a MAXIMUM of **seven (7) consecutive days**, according to the following "Reasons for Encounter (RFE)" categories.*

You must enter the dates of the data collection in the table below.

RFE may be in the form of symptoms, requests for services, or as diagnostic descriptions volunteered by the patients. Only one RFE per consultation is to be entered (you may categorise the case based of the main RFE).

Providing false or misleading information will lead to the rejection of a candidate's application or prohibition from the examinations. The Censor Board considers it a serious offense if a candidate submits false, incomplete, or misleading information to AFPM.

Dates of encounter: **From** dd / mm / yyyy **to** dd / mm / yyyy		**Paed < 12 years**		**Adult**		**Total** (digits)
		Male	**Female**	**Male**	**Female**	
1.	Respiratory					
2.	Dermatological/Skin					
3.	Cardiovascular/Circulatory					
4.	Gastrointestinal/Digestive					
5.	Musculoskeletal					
6.	Neurological					
7.	Urological					
8.	Endocrine, Metabolic, Nutritional					
9.	Haematological/Blood					
10.	Eye					
11.	ENT					
12.	Pregnancy, Childbirth, Family Planning					
13.	Gynaecological & Breast					

14.	Men's health					
15.	Psychological					
16.	Social Problems					
17.	General & Unspecified – fever, pain, tiredness, weakness.					
18.	Aesthetics					
19.	Request for medical check-up					
20.	Request for immunization					
21.	Request for test (X-ray, USS, Lab, etc)					
22.	Request for treatment and therapeutic procedure					
23.	Request for prescription/repeat medication/Over the counter prescription					
24.	Test results - request for explanation and/or report					
25.	Request for medical report (e.g., Insurance Medical, Medico-Legal)					
26.	Request for medical leave without consultation					
27.	Others: e.g., Request for referral, follow-up initiated by doctor, etc.					
TOTAL ***(digits)*** ***Please add up the totals for each column at the bottom.***						

**Each patient visits to be entered once only.*

**E.g. Patients with DM and Hypertension who came for follow-up can be categorized as "3. (cardiovascular)" or "8. (Endocrine, Metabolic, Nutritional)"*

THE APPLICATION FEES:	
Examination Fees	RM 4,800.00
Processing Fees (non-refundable)	RM 1,000.00
Total Payable	**RM 5,800.00**

REFUND POLICY:

Processing fees (RM1000) paid are non-refundable.

If a candidate defers or withdraws from the examination, the candidate may request a refund (minus the processing fee) of the examination fee. Section 3.0 Fees and Refund Policy of *AFPM Postgraduates Course Guideline and Policy Handbook states:*

3.1. Refund for the examination fee must be approved by the Board of Censors. The refund of the structure for the examination fee is as follows:

3.1.1. A 100% refund will be issued if a candidate withdraws from the examination before the Board of Censors (BOC) reviews their application.

3.1.2. A 75% refund will be issued if a candidate is deemed ineligible to sit for the exam or withdraws for valid reasons more than one (1) month before the scheduled examination date.

3.1.3. A 50% refund will be issued if a candidate withdraws from the examination less than one (1) month before the scheduled examination date due valid reason.

3.1.4. 0% refund for candidates who withdraw from the examination within 36 hours of the examination start time or who are unable to complete the examination for any reason.

Please maintain a duplicate copy of this Application Form for your reference.

DECLARATION BY THE CANDIDATE:

I declare that the information, documents, and materials given above or attached to this application form are true, complete and not misleading in any form or manner and I shall abide by all the rules, regulations, policies, and guidelines as set by the AFPM including all updates, amendments, variations and additions thereto. I further acknowledge, understand and agree that: -

1) I have satisfied all the requirements to sit for Part II of the Conjoint MAFP/FRACGP/icFRACGP Examination;

2) I shall adhere to all the terms, conditions, rules, regulation, information, policies and guidelines (collectively, "Guidelines and Policies") pertaining to the Part II of the Conjoint MAFP/FRACGP/icFRACGP Examination including but not limited to;

   a) the 'AFPM Postgraduate Courses Guidelines and Policy Handbook' ("Handbook"),

   b) the criteria to sit and pass the Part II Conjoint MAFP/FRACGP/icFRACGP Examinations,

   c) examination rules and regulations according to the examination handbook,

   d) any terms and requirement given by the Board of Censors and Board of Examiners,

   e) the criteria for the award of MAFP and/or FRACGP/icFRACGP at the AFPM website,

   f) AFPM's policy on fees payments and refunds, and

   g) AFPM's privacy policy

3) Successful completion of the GCFM Programme or the ATFM Programme or passing the GCFM Final Professional Examination and the Part I or II Conjoint MAFP/FRACGP/icFRACGP Examinations do not automatically award any candidate with the MAFP or FRACGP/icFRACGP qualifications;

4) The processing fee of RM1,000.00 is non-refundable and my application shall not be processed if the examination fee is not paid in full;

5) AFPM reserves the right to reject any incomplete, inaccurate or delayed application form;

6) AFPM reserves the right to update, amend, vary, supplement or reverse any decision regarding my Part I or II Conjoint MAFP/FRACGP/icFRACGP Examinations eligibility and examination result if my application is made on the basis of incorrect, incomplete and/or misleading information, documents or materials;

7) AFPM reserves the right to amend the Part II of the MAFP/FRACGP/icFRACGP Conjoint Examination schedule as may be necessary;

8) AFPM may seek verification directly from the source of documentation that I have provided to support my application;

9) AFPM reserves the right to notify the authorities, regulators, bodies, associations, tertiary institutions, hospitals, clinics, or any medical or pharmaceutical institutions if any of the information, document, or material presented to support my application is found to be false;

10) All documents submitted to AFPM shall become the property of AFPM and will not be returned; and

11) The Handbook and Guidelines and Policies pertaining to the Part II of the Conjoint MAFP/FRACGP/icFRACGP Examination may be updated or amended from time to time and I shall ensure that I am made aware of such updates or amendments by reviewing all the Guidelines and Policies in the AFPM website from time to time and I shall adhere to any such updates, amendments, variations and/ supplements.

I enclose herewith the examination fee in full via:

Online transaction dated_____ into Am Bank (Account Number: 001-201-010181-2) amounting RM_____ (with attached proof of payment).

THIS IS MY EXAMINATION ATTEMPT (Indicate attempt with ✓)

First attempt ☐ Second attempt ☐ Third attempt ☐

I hereby apply to sit for the examination in the month of **September 2025.**

Applicant's Signature

Name:

NRIC/Passport number:

Date:

APPENDIX A

Letter of Good Standing on Professional, ethical and organisational role – to be filled by trainee's workplace supervisor.

Name of Trainee: _____

Period of supervision: From: dd / mm / yyyy to dd / mm / yyyy

Name of practice: _____

Name of Supervisor: _____

MMC and NSR Number: _____

Describe how you assessed the trainee's performance:

Rating scale:

1: Consistently performed below the expected level of a prospective specialist

2: Sometimes performed below the expected level of a prospective specialist

3: Consistently performed at the expected level of a prospective specialist

4: Consistently performed above the level of a prospective specialist

	1	2	3	4
Adherence to the standard ethical and professional code of conduct.				
Recognizes personal limits in competence and capabilities; seeks guidance and accepts feedback when necessary.				

Demonstrates strong accountability such as by reliably fulfilling their responsibilities, adhering to organisation's policies, or proactively communicating updates or absences.				
Capable of working efficiently within a healthcare team, valuing others' experiences.				

Has this trainee been a subject of professional misconduct enquiry at the workplace within the last 12 months?

☐ YES ☐ NO

Do you support this trainee's application to sit the specialist clinical competency examination?

☐ YES ☐ NO

Any comments:

Supervisor's signature

Name of supervisor:

Date:

LAST PAGE OF THE APPLICATION FORM