ACADEMY OF FAMILY PHYSICIANS OF MALAYSIA
(Akademi Kedoktoran Keluarga Malaysia)

APPLICATION FORM FOR ADMISSION TO THE ADVANCED TRAINING IN FAMILY MEDICINE PROGRAMME ("ATFM PROGRAMME")

APPLICATION PROCEDURES:

1. Please use **CAPITAL LETTERS** and in **BLACK INK** only.

2. All applications must reach the secretariat of the AFPM at the address provided below on or before the closing date which is **12th May 2024 (for passed GCFM candidates) / 21st July 2024 (for GCFM candidates who passed the May 2024 exam).**

3. Payment by cheque, bank draft, online banking or telegraphic transfer shall be made payable to the "**ACADEMY OF FAMILY PHYSICIANS OF MALAYSIA**" (Bank : Am Bank; Account Number: **001-201-010182-0**). For online banking/telegraphic transfer, please forward the proof of payment by emailing the banking receipt to accounts@afpm.org.my / afpm@po.jaring.asia. No cash payment will be accepted.

4. A non-refundable processing fee of **RM500.00** shall be paid by the applicant upon submission of this application form. This application shall not be processed if the processing fee is not paid.

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 applicant.

6. Completed application form must be sent by POST to:

   THE ACADEMY OF FAMILY PHYSICIANS OF MALAYSIA,
   UNIT 1-5, LEVEL 1, HIVE 4 TAMAN TEKNOLOGI MRANTI,
   JALAN INNOVASI 1 LEBUHRAYA PUCHONG-SUNGAI BESI
   BUKIT JALIL, 57000 KUALA LUMPUR.
   PHONE: 603-89939176 / 9177 FAX: 603-8993 9187

***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**

CHECK LIST:

- ☐ 1. I have checked and read the entry criteria for the ATFM Programme and confirm that I meet all the criteria therein.
- ☐ 2. I have read and understood all the information in the 'AFPM Postgraduate Courses Guidelines and Policy Handbook' and all the rules, information, policies, and guidelines in AFPM's website.
- ☐ 3. Fully completed form (all sections).
- ☐ 4. One certified true copy of NRIC (for Malaysian) / certified true copy of the relevant pages of passport – i.e. identification pages (for non–Malaysian applicants).
- ☐ 5. One certified true copy of **CURRENT** Annual Practicing Certificate ("APC").
- ☐ 6. One certified true copy of Certificate of Full Registration with the Malaysian Medical Council (MMC).
- ☐ 7. Verification of current employment (Employer's letter, Letter from district health office, or Borang B/F).
- ☐ 8. Proof of AFPM Membership Status.
- ☐ 9. One certified true copy of Basic Medical Degree and other relevant degrees.
- ☐ 10. One certified true copy of GCFM certificate of completion or result letter.
- ☐ 11. Work Experience in the last 10 years (Appendix A).
- ☐ 12. RFE Table (Appendix B).
- ☐ 13. Signed PDPA Form.
- ☐ 14. Appendix C: Consent for personal information sharing with Yayasan Peneraju Pendikan Bumiputera (if applicable).
- ☐ 15. Processing fee of RM500.00.

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.

(updated Mac 2023)

APPLICATION FORM FOR ADMISSION
ADVANCED TRAINING IN FAMILY MEDICINE PROGRAMME (ATFM)

(For Members of AFPM only)

A. PERSONAL PARTICULARS (FILL USING CAPITAL LETTERS AND BLACK INK)

Full Name:			
Date of Birth:	**Age:**		**NRIC No / Passport No:**
Ethnicity:	**Citizenship:**		**Country of Origin:**
Gender: Male Female	**Marital Status:**		**AFPM Membership No:**
Full Medical Registration No:	**Date Issued:**		**Current Annual Practicing Certificate No:**
Type of Practice (please circle):	Klinik Kesihatan (KK Type 1-4)	Klinik Kesihatan (KK Type 5-7)	GP Clinic
	MINDEF	University	Other:
Email Address:			
Home Address:			
Postcode:	**District:**		**State:**
Telephone No:	**(Mobile)**		**(Home)**

Name and address of current workplace:			
Postcode:	**District:**		**State:**
Telephone No:	**(Mobile)**		**(Landline)**

- **For MOH Candidates, please supply corresponding PKD address here:**
- **For GP candidates, please supply Clinic Main Branch if applicable:**

Name & Address:					
	State:		**Country:**	**Postcode:**	
	Telephone No:	**(O)**			
Preferred Mailing Address (please circle):	**Home**		**Workplace**		

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)**

Details on third practice (name and address):		
Postcode:	**District:**	**State:**
Telephone No:	**(Mobile)**	**(Landline)**

What hours do you work each day? (eg. 8am to 5pm, 2pm to 8pm etc.)							
Practice name:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

B. EDUCATIONAL BACKGROUND INCLUSIVE OF POST GRADUATE QUALIFICATIONS

Date Obtained			Qualification	Name of College / University / Academy
Day	**Month**	**Year**		

C. WORKING EXPERIENCE

GENERAL PRACTICE/ PRIMARY CARE EXPERIENCE								
From			To			Position (e.g. Principle, Part-time, etc.)	Address	Type of Practice (Solo / Group / etc)
Day	**Month**	**Year**	**Day**	**Month**	**Year**			
Duration :								

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Duration :								
Duration :								
Duration :								

D. ADDITIONAL SPECIALIST EXPERIENCE IN SUPPORT OF ENTRY TO THE PROGRAMME

MEDICAL OFFICER IN SPECIALISED MEDICAL UNITS							
From			**To**			**Hospital / Unit**	**Address**
Day	**Month**	**Year**	**Day**	**Month**	**Year**		
Duration :							
Duration :							
Duration :							

E. GAPS IN EMPLOYMENT HISTORY. *(Kindly provide information on unemployment period or extended leave such as maternity leave, unpaid leave, or long period of sick leave you had in the past)*

Start			**To**			**Explanation**
Day	**Month**	**Year**	**Day**	**Month**	**Year**	
Duration :						
Duration :						
Duration :						
Duration :						

F. COURSE FEE:

All Applicants …… **RM 14,000.00 per year**

G. REFUND POLICY:

NO REFUND WILL BE CONSIDERED AFTER AN APPLICANT'S ENROLMENT INTO THE ATFM PROGRAMME. THE APPLICANT IS CONSIDERED ENROLLED ON THE ENROLMENT DATE AS SET OUT IN THE OFFER LETTER.

H. DECLARATION

I declare that the information, documents and materials given above or attached to this application form are true, and 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 shall adhere to all the terms, conditions, rules, regulation, information, policies and guidelines (collectively, "Guidelines and Policies") pertaining to the Advanced Training in Family Medicine programme ("ATFM Programme") including but not limited to (a) the 'AFPM Postgraduate Courses Guidelines and Policy Handbook' ("Handbook"), (b) the entry criteria for the ATFM Programme and criteria to sit and pass for the Part I & II Conjoint MAFP/icFRACGP Examinations; (c) criteria for the award of MAFP & icFRACGP at the AFPM website, (d) AFPM's policy on admission, fees payments and fees refunds and (e) AFPM's privacy policy;
2) Successful completion of the Graduate Certificate in Family Medicine ("GCFM") programme and the ATFM Programme or passing the GCFM Final Professional Examination and the Part I & II MAFP/icFRACGP Conjoint Examinations do not award any candidate with the MAFP or icFRACGP qualifications;
3) The processing fee of RM500.00 is non-refundable and that my application shall not be processed if the processing fee is not paid in full;
4) AFPM reserves the right to reject any incomplete, inaccurate or delayed application form;
5) AFPM reserves the right to update, amend, vary, supplement or reverse any decision regarding my admission or enrolment into the ATFM Programme if my application is made on the basis of incorrect, incomplete and/or misleading information, documents or materials;
6) AFPM reserves the right to amend the ATFM Programme schedule as may be necessary;
7) acceptance of my application into the ATFM Programme shall be subject to the approval of the Faculty of Education and the Board of Censors;
8) AFPM reserves the right to inform 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;
9) All documents submitted to AFPM shall become the property of AFPM and will not be returned;
10) AFPM may seek verification directly from the source of documentation that I have provided to support my application; and
11) The Handbook and the Guidelines and Policies pertaining to the ATFM Programme may be updated, amended, varied or supplemented from time to time and I shall ensure that I am made aware of such updates or amendments by reviewing the all the information and Guidelines and Policies in the AFPM website from time to time and I shall adhere to any such updates, amendments, variation and/or supplementals.

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Applicant's Signature

Date: _____

Name: _____

NRIC/Passport number: _____

FOR OFFICIAL USE

Date Received:		Receipt No.:	
Received By:		AFPM Member-in-benefit: Yes No	
The year completed GCFM:			
Application for ATFM Intake:	14	Year:	2024
		Yes	**No**
NRIC/Passport			
MMC Full Registration and APC 2024			
Basic medical degree			
Proof of passing GCFM			
Employment verification – letter from PKD/HR/Borang B or F			
Currently in a recognised GP practice			
Practising ≥ 38 hours per week			
Acceptable work schedule			
Appendix A: complete and consistent			
Adequate GPE from Mac 2021 to Aug 2024 (≥ 2yr 7m)			
Appendix B: RFE Table - Is the practice adequate for training?			
Signed declaration and PDPA Form			
Appendix C: Consent for release of information to Yayasan Peneraju.			
Approved for ATFM 2024		**Yes**	**No**
Remark:			
Vetted by: (Censor Name)		Date:	
Censor Signature:			

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APPENDIX A

WORK EXPERIENCE INCLUSIVE OF FAMILY PRACTICE / GENERAL PRACTICE IN LAST 10 YEARS				
EXACT DATES DD/MM/YY – DD/MM/YY	**FULL-TIME**	**DURATION YEARS, MONTH**	**PART-TIME**	**DURATION YEARS, MONTH**
CANDIDATE'S NAME:			**DATE:**	
CURRENT PLACE OF PRACTICE:			**OFFICE TEL NO:**	

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APPENDIX B

The aim of this data collection is to provide a general view of the patients seen and managed in your Practice.

Record **all** the patients who consulted you in a given **one (1) week** in the following categories according to the Reasons for Encounter (RFE). **RFE** may be in the form of symptoms, requests for services, or as diagnostic descriptions volunteered by the patients. Only one / the **main** RFE per consultation is to be entered. You **must** enter the **dates** of the given week for which the patients have consulted you. Numbers 1 to 17 are used when the RFE are in the form of symptoms, complaints, diagnoses or diseases.

Any false or misleading information will result in a candidate's application being rejected or a candidate being barred from the programmes and/or examinations and/or from being awarded the respective award of recognition. The Censor Board finds it a serious offence when a candidate has provided, or is discovered to have provided, AFPM with false, incomplete or misleading information (including giving false information with regards to the place of practice and nature of practice) or to have omitted any relevant or material information.

Name of Applicant: .....

Place of Practice: .....

Reasons for Encounter from *(please insert dates)* ..... **to**		**Paed < 12 years**		**Adult**		**Total**
		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 without consultation (such as 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 *(please total up accordingly)*						

**each patient visits to be entered once only. E.g. Patients with DM and Hypertension who came for follow-up can be categorized either as "3. (cardiovascular)" or "8. (Endocrine, Metabolic, Nutritional)"*

I declare that the information, documents and materials given above or attached to this application form are true, and complete and not misleading in any form or manner. I acknowledge, understand and agree that AFPM may seek verification directly from the source of documentation that I have provided to support my application.

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Applicant's Signature

Date: _____

Name: _____

NRIC/Passport number: _____

APPENDIX C

YAYASAN PENERAJU PENDIDIKAN BUMIPUTERA – Peneraju Spesialist Education Fund

I am interested to apply for the Yayasan Peneraju Education Fund.

I fulfilled the general criteria:

☐ Bumiputera

☐ Age <45

I, hereby agree for AFPM to share my name, email and telephone numbers, or any other information required to assist with my application with the Yayasan Peneraju.

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Applicant's Signature

Date: _____

Name: _____

NRIC/Passport number: _____

AFPM