



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



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

APPLICATION PROCEDURES:

1. Please download this form and fill using **CAPITAL LETTERS** and in **BLACK INK** only.
2. All applications must be submitted to the secretariat of the AFPM on or preferably **before** the closing date which is on **11th May 2025 (for passed GCFM candidates) / 20th July 2025 (for GCFM candidates who passed the May 2025 exam)**. Late applications will **NOT** be accepted.
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. Incomplete applications forms or inadequate supportive documents shall not be processed by the Board of Censors
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 personalized link with any other parties.
8. Applicants must request the secured link from the APFM IT team (Please cc your email request to Ms Mala: mala@afpm.org.my & Mr Amin : amin@afpm.org.my)
 - a) Mr Saufi Omar: saufiom@afpm.org.my
 - b) Mr Afdal Diyauudin: 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**

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 Practising 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 Pendidikan 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: | | | Hadiah Latihan Persekutuan (HLP): Yes / No | | | Post : Contract/Permanent | |

- 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 : | | | |
|-------------------|--|--|--|

| | | | | | | | | | |
|-------------------|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
| 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.

.....
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: | <input type="text"/> | |
| Application for ATFM Intake: | <input type="text" value="15"/> | Year: <input type="text" value="2025"/> |
| | Yes | No |
| NRIC/Passport | | |
| MMC Full Registration and APC 2025 | | |
| 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 2022 to Aug 2025 (≥ 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 2025 | Yes | No |
| Remark: | | |
| Vetted by: (Censor Name) | | Date: |
| Censor Signature: | | |

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:

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 (maximum seven consecutive days only)** 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 (<i>please insert dates</i>) 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.

.....
Applicant’s Signature

Date: _____

Name: _____

NRIC/Passport number: _____

APPENDIX C

YAYASAN PENERAJU PENDIDIKAN BUMIPUTERA – Peneraju Specialist 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.

.....
Applicant's Signature

Date: _____

Name: _____

NRIC/Passport number: _____