

Instructions

Section A: All applicants must complete this section.
 Section B: Only self-employed applicants should complete this section.
 Section C: Only employees (not self-employed) applicants should complete this section.
 Sections D, E & F: All applicants must complete these sections.

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

PEPA MANAGER NT
 Territory Palliative Care
 Royal Darwin Hospital
 PO Box 41326
Casuarina NT 0811
 or fax to: 08 8922 6775

Privacy & Confidentiality

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
- Confirmation of current registration / authority to practice

Please indicate your agreement by ticking the following: *(please tick boxes below)*

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.
 I consent to my name and contact details, being forwarded to the National Coordinator for program evaluation.
 I consent to my program report being forwarded to National Coordinator for use in program evaluation.

Applicants Details

Title Mr Mrs Ms Dr Other _____

Surname: _____

Given Name(s): _____

Postal Address: _____

Daytime Phone: _____

Mobile Phone: _____

Email Address: _____

Next of Kin (in case of emergency) _____ Name of Next of Kin / Emergency Contact _____ Phone Number of Contact _____

Section A: Eligibility Criteria

Q1. Does your current work involve care for people with life-limiting illness?
 Yes
 No (You cannot proceed any further if you tick this box)

Q2. What qualifications do you currently hold? *Please list in the space provided below.*

Year Completed	Qualification & Name of Educational Institution
_____	_____
_____	_____
_____	_____

Q3. Is your registration / practising certificate current?
 Yes (You must provide details in the space provided and attach evidence)
 No (You cannot proceed any further if you tick this box)
 Not Applicable (for non-regulated workers/carers)

PEPA MANAGER USE ONLY

Date Received ____/____/____ Approved ____/____/____ PEPA Manager _____
 Date Notified ____/____/____ Host Site _____ Placement Dates ____/____/____

Registration Number	Registering Authority	Renewal Date

Q4. If undertaking placements, which may involve interactions with children, have you obtained *Working with Children* or other appropriate authority as required by legislation and local institutional policies?
 Yes (You must attach evidence) No (You cannot proceed any further if you tick this box)

Q5. Are you self-employed?
 Yes (Go to Section B of this application) No (Go to Section C of this application)

Section B: Self-employed Applicants Only

All self-employed applicants are required to provide their own insurance per the *National Management Guidelines*.

Q1. Will you be covered by your Work Cover policy (or insurance for personal accident) throughout attendance on the PEPA placement?
 Yes (please attach documentary evidence) No (You cannot proceed any further if you tick this box)

Q2. Do you currently have a Work Cover Claim?
 Yes (go to question 3) No

Q3. If yes, 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 documentary evidence 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 documentary evidence of your current insurances as above.

Place of Work: _____
 Position Title: _____
 Work Address: _____

 Work Email: _____
 Work Phone: _____

_____ / ____ / ____
 Self-employed persons Signature Date

Section C: 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 Work Cover Policy while undertaking a PEPA Placement?
 Yes No (Applicant cannot proceed any further if you tick this box)

Q2. Does the applicant currently have a Work Cover claim?
 Yes (Go to question 3) No (Go to question 4)

Q3. 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

Q4. 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

Q5. Have you read the PEPA Information and Application Kit, and understand the requirements for participation in the program?

- Yes No

_____/_____/_____
 Manager's Signature Date

Northern Territory Government (NTG) Employees and clinics only:

Managers should ensure the **HE47 Training Application Form** is also completed, approved and forwarded to DHF so that training can be recorded in PIPS. (NTG Employees and Clinics only)

Section D: Placement Preferences

Please indicate placement preference:

- Territory Palliative Care Community team, Darwin Territory Palliative Care Community team, Alice Springs
 Territory Hospice, Royal Darwin Hospital, Darwin Other (please specify) _____

Q1. If available, would you be interested in a mixed placement? (E.g. some days at an in-patient palliative care service and some days at community or local service)? Yes No

Q2. What are your preferred dates or month of the year for a placement?

Q3. Are there any times that you would **not** be available for a placement?

Q4. Would you prefer a block of two weeks (**max. 4 days for G.P.'s**) or another arrangement of days?

Q5. Are there any other constraints that would impact on your uptake of a placement (e.g. childcare)?

Section E: Applicants Declaration

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 / divulge any information to any person, organisation or body, by any means (electronic, verbal, hard copy or other means).

I declare that I do not have any current or pending misconduct or other legal proceedings against me.

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 & Application Kit.

Applicant's Signature Date _____/_____/_____

Section F: Applicants Checklist

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

- Certified copy of your current professional registration or license to practice.
 Certified copies of your current insurances (applicable to self-employed applicants only).
 Certified copy of *Working with Children* authority (if applicable)

APPLICANT'S NAME: _____

All applicants must complete this section.

Please copy this page, and take with you to your clinical placement. If more space is required, please attach an additional sheet.

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. Describe 3 key outcomes you want to achieve during your PEPA placement?

Q4. How will you disseminate information or implement a quality activity 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 activity within their workplace, within 4 – 6 weeks. A brief report on this activity is to be submitted within 3 months of completion of placement to the PEPA Manager.

Examples of activities that previous participants have undertaken include:

- *Development of new policy*
- *Development of patient assessment tools*
- *Setting up support networks*
- *In-service education*
- *Resource folders for patients and staff*
- *Establishment of a Palliative Care Committee*
- *Formal staff education*
- *Introduction of complimentary therapies to service*
- *Implement multi-disciplinary team meetings*