



**Program of Experience in the Palliative Approach**

Funded by the Australian Government  
Department of Health and Ageing

THE NATIONAL CARE PROGRAM

**APPLICATION FORM**  
SA /MET/112/0746

**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:

**SA PEPA MANAGER**  
**Statewide Strategic Projects, Operational Strategy.**  
**South Australian Department of Health**  
**PO Box 287, Rundle Mall**  
**Adelaide SA 5000**

**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 tick**

- I understand and agree to the information I have provided to be used for the above purposes.
- I consent to my name/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 medical 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)

Registration Number	Registering Authority	Renewal Date

**PEPA MANAGER USE ONLY**

Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_ Approved \_\_\_\_/\_\_\_\_/\_\_\_\_ PEPA Manager \_\_\_\_\_

Date Notified \_\_\_\_/\_\_\_\_/\_\_\_\_ Host Site \_\_\_\_\_ Placement Dates \_\_\_\_/\_\_\_\_/\_\_\_\_

Q4. Has your police check been completed (applicable for Paediatric Palliative Care Service placement only)?

- Yes (You must attach evidence)  No (You cannot proceed any further)

Q5. Are you self-employed?

- Yes (Go to Section B of this application)  No (Go to Section C of this application)

**Section B: For General Practitioners who are Self-employed**

All General Practitioner applicants are required to provide the following insurance information.

Q1. Do you have Medical Indemnity Insurance?

- 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: \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 General Practitioners 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

**Section D: Placement Preferences**

**Please Note: Placement preferences will be taken into account where possible.**

- |   |                                    |                                    |   |
|---|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Local palliative care service        | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |
| <input type="checkbox"/> Regional palliative care service     | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |
| <input type="checkbox"/> Metropolitan palliative care service | <input type="checkbox"/> inpatient | <input type="checkbox"/> community | <input type="checkbox"/> hospital based consultancy |

Q1. If available, would you be interested in a mixed placement? (E.g. 1-2 days at a regional/metropolitan palliative care service and 1-2 days at your local service)?  Yes  No

Q2. What are your preferred dates / times for a placement?

---

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

---

Q4. 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 (only applicable to self-employed applicants).
- Certified copies of your 'name only' police check (only required for participants seeking placement with the Paediatric Palliative Care Service – see the 'Authority to Access Person History Information Form' and associated proof of identity requirements found at the SA PEPA website).

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 will 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 activity within their workplace, within 4 – 6 weeks.*

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*