



ENRICHMENT TRAINING APPLICATION

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Health Region / Preceptor

- Has your AHS medical leader identified a need for this training? No Yes
- Have they agreed to provide the necessary letters of support for your training? No Yes
- Will AHS cover any costs required to practice the new skills when your training is complete? No Yes
- PLEASE NOTE: Documentation will be required before approval of your application.

Do you require locum coverage? No Yes

Has a preceptor agreed to provide the training? No Yes

Preceptor's Name _____

Phone number (____) _____

If no preceptor has agreed to provide training, we will first forward your application when accepted to the Faculty liaison at the Universities of Calgary or Alberta.

PLEASE BE ADVISED: The duration of your training program will be influenced by your stated objectives and the opinion of the preceptor.

Application Form Waiver

(Please Read Carefully)

In exchange for the consideration of my application, I agree that:

I will be required to participate in an evaluation program designed to assess the outcomes of my training. This may include the maintaining of a log of procedures performed, cases seen and treated or referred, personal assessment of your training program and Alberta Health Services (AHS) response to your training. Both the AHS medical leader and I will be asked to comment on the program and areas for improvement. Therefore, I may be contacted in the future by the RPAP or its agents to assess the quality and effectiveness of the Enrichment Training program, and I agree to be contacted and to participate in any evaluation for this purpose.

I also agree that the information collected from and during this application shall be used by RPAP for program administration, payment and evaluation of the Enrichment Program by the RPAP.

I authorize the investigation of all statements contained in this application. I understand that any misrepresentation or omission of facts called for is cause for rejection of my application or removal from training at any time without any previous notice. I hereby give the RPAP permission to contact medical schools, references, and others, and hereby release the RPAP, its employees and agents from any liability as a result of such contact.

I also understand that the honorarium provided to me by the RPAP is to assist with the costs associated in leaving my practice to gain the additional skills needed in my community, and that no agency, partnership, or employee/employer relationship exists. The honorarium does not include any benefits such as health care insurance, life insurance or vacation entitlement. Maintenance of such benefits or payment of taxes and pensions is my own responsibility.

I shall indemnify and hold harmless the RPAP, the Minister of Health and Wellness, their employees and agents from any and all claims, demands, actions and costs of any kind whatsoever, that may arise directly or indirectly out of any acts or omissions of myself during my period of training.

I commit to return to rural practice in Alberta after my enrichment training is completed.

Signature _____

Date: _____

The personal information requested on this form is collected for the purpose of administering and processing payments to preceptors, vendors, students, residents, contractors and staff involved with RPAP. If you have any questions about the collection, use, or disposal of the information requested, please contact: Executive Director, The Alberta Rural Physician Action Plan, 2801 Telus House, 10020-100 Street NW, Edmonton, AB T5J 0N3. Phone 780-423-9911 Fax: 780-423-9917.

The Alberta Rural Physician Action Plan
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