|  |  |  |  |
| --- | --- | --- | --- |
| **Local Health Network details** |  | **Term details** |  |
|  |  |  |  |  |
| **LHN Name** |  | **Name** |  |  |
|  |  |  |
| **Site Name** |  | **Term Supervisor** |  |  |
|  |  |  |  |  |  |
| **Contact Person:** |  |  | **Start Date** |  |  |
|  |  |  |  |  |  |
| **Contact No:** |  |  | **TMO Level:** |  |  |
|  |  |
|  |  |
| **Approval**  |
| **Director of Clinical Training *(print name):*** |  |  |
|  |  |  |
| **Signature:** |  |  |
|  |  |  |
| **Date:** |  |  |
|  |

**About this form**

The purpose of this form is to identify an accreditation change in circumstance in local health networks (LHNs) to determine whether the level of the change is *significant*, *moderate* or *minor*.

The form is to be reviewed and approved by the Director of Clinical Training prior to sending to the SA MET Unit for processing.

The ***Change in Circumstance Process*** document will assist in completing this form. The form aligns with the South Australian Medical Education and Training Health Advisory Council Accreditation Standards (Accreditation Standards).

**Instructions**

On completion of the form refer to the ***Change in Circumstance – Risk Management Process*** to identify the appropriate approval process to follow prior to implementing the change.

[ ]  Attached Updated Term Description (mandatory)

Please note that an incomplete or insufficient Change of Circumstance assessment form and updated Term Description will delay the assessment process.

**Levels of change in circumstance**

|  |  |
| --- | --- |
| **Significant** | Having, or likely to have a major impact on the education and training received by TMOs and the subsequent requirement to meet the Accreditation Standards. |
|  |  |
| **Moderate** | Having, or likely to have change within a reasonable limit; not considered excessive, on the education and training received by TMOs and requirement to meet the Accreditation Standards |
|  |  |
| **Minor** | Having, or likely to have a change of lesser impact on the education and training received by TMOs and subsequent requirement to meet the Accreditation Standards. |
|  |  |

|  |
| --- |
| **Level of Change (please tick)** |
| Significant [ ]  | Moderate [ ]  | Minor [ ]  |

|  |
| --- |
| 1. **Please clearly describe the proposed change that will occur.**

*(NB: include the intended commencement date of the change)* |
|  |
| 1. **Please outline the reasons behind the need for the change.**

*(NB: What has prompted the change to the rotation/term)* |
|  |
| 1. **Specifically, how will the junior doctors be affected?**

*(NB: Detail the impacts on rostering, supervision, rostered hours, assessment, education and training)* |
|  |
| 1. **Please provide any further relevant information (optional)**
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|  |