|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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)** |
|  |