MSF APPLICATION for ACRRM ASSESSMENT

NAME: (Dr)		ACRRM MEMBERSHIP No.	
POSTAL ADDRESS:		STATE	POSTCODE
CONTACT TEL. No.:		EMAIL ADDRESS:	

TYPE OF ENVIRONMENT – please select						TRAINING PATHWAY – please select		
GP ☐	Rural Hospital ☐	RFDS ☐	AMS ☐	EM Dept. ☐	Other –please specify	AGPT ☐	RVTS ☐	IP ☐

SCHEDULE OF FEES

Please tick appropriate box

	***COMPLETE MSF** (includes DISQ & CFET)*	***$451.00***
	DISQ COMPONENT ONLY	***$225.50***
	CFET COMPONENT ONLY	***$225.50***

MSF must be completed within four (4) months of enrolment

ASSESSMENT COMPONENTS UNDERTAKEN WITHIN PREVIOUS 18 MONTHS

	DATE Report received	REGIONAL TRAINING PROVIDER
DISQ		
CFET		

N.B. CFEP may be able to confirm date of report received if unknown.

☐ I give permission for the reports of any assessment components I have previously undertaken during training to be sent to FACRRM to contribute to the assessment requirements.

☐ I give permission for ACRRM to provide my RTP with my MSF report (if applicable). This ensures your training provider is informed of your ongoing progress throughout your training.

SIGNATURE _____ ***DATE*** _____

Payment has been made for the amount of $ by the following method:

☐ **Bank Transfer:** Focused Evaluations Program Pty Ltd; BSB – 064110; Acc. No. – 10276795
(For reference please provide YOUR NAME as written above.)

☐ **Cheque:** made payable to 'Client Focused Evaluations Program' or CFEP'

☐ **Credit Card:** (please note a Bank Service Fee of 1.5% will be added to all credit Card transactions)

☐ Mastercard ☐ Visa

Card No.: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __ Expiry date: __ __ / __ __

Name on card: _____

SIGNATURE: _____ DATE: _____

Please return this form:

Post: CFEP, PO Box 588, Everton Park, QLD 4053
Fax: (07) 3355 7047
Email: info@cfepsurveys.com.au