



The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

"Excellence in Women's Health"

www.ranzcog.edu.au

CPD Educator Activities

RANZCOG Training Supervision & IHCA Verification

Educator points can be claimed by Fellows who are RANZCOG-approved providers for training supervision in the Integrated Training Program (ITP), or RANZCOG-approved assessors of In-Hospital Clinical Assessment (IHCA) modules.

- ✓ Points can be claimed for training supervision on the basis of five points per trainee up to a maximum of 20 points per 3-year CPD period.
- ✓ Points can be claimed for IHCA on the basis of five points per assessment.
- ✗ Points cannot be claimed for preparation time or actual time taken. You cannot claim points if you are not a registered training provider with RANZCOG or on the list of assessors approved by the RANZCOG Examinations Committee.



You are requested to retain any **one** of the following for verification documentation purposes (to be kept by you and only sent to RANZCOG if requested):

- Completed "RANZCOG Training Supervision and IHCA Verification Template" or similar model with signature of ITP Co-ordinator, Head of Department or Hospital Administrator
- Signed letter from ITP Co-ordinator, Head of Department or Hospital Administrator confirming your training supervision, including date/s, location, and name of trainee.
- Certificate from RANZCOG

Note that if you supervise or assess a number of trainees you may complete one template or letter listing the dates, location and names of the trainees.

Please keep a summary of your activity as verification documentation

To claim points in the Educator activities category, enter the number of points on your Annual Points Claim form.

Completion of this activity – 5 Points/trainee supervised up to 20 points per CPD period

5 Points/assessment in the Educator activities category

For queries contact CPD staff on +61 3 9417 1699 or vspark@ranzcog.edu.au



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RANZCOG Training Supervision & IHCA Verification Template

This form has been designed to assist Fellows in obtaining verification for their training supervision and In-Hospital Clinical Assessments.

Health Service/Hospital/Institution name: _____

Fellow's name: _____ Fellowship ID: _____

What was the date/s, location/s and name/s of the trainee/s supervised/assessed?

Date	Location	Name of Trainee	Name of IHCA module*

**Name of IHCA module only required for IHCA assessors*

To be signed by ITP Co-ordinator, Head of Department or Hospital Administrator

Signed: _____ Date: _____

Name: _____ Position: _____