APPENDIX O(1):

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA
PROFESSIONAL BOARD FOR RADIOGRAPHY AND CLINICAL TECHNOLOGY

APPLICATION FOR ACCREDITATION OF A CLINICAL TRAINING FACILITY/UNIT IN CLINICAL TECHNOLOGY

1. HIGHER EDUCATION INSTITUTION DETAILS:

Higher Educational Institution	
Name of Department	
Name of Head of Department	
Contact Person	
Postal Address	
Physical Address	
Telephone Number	
Fax Number	
E-mail address	

Note: All information requested below is for the specific clinical facility/unit being evaluated.

2. Purpose of request for accreditation of clinical training facility:

New accreditation		**Re- accreditation**	
		Date of previous accreditation	

3. Clinical Technology discipline/specialisation for accreditation / re-accreditation:

Cardiology		**Nephrology**		**Pulmonology**		**Neurophysiology**	
Critical Care		**Cardiovascular Perfusion**		**Reproductive Biology**			

4. CLINICAL TRAINING FACILITY/UNIT DETAILS: (i.e. details for this facility/unit)

4.1 This is a:

Primary clinical training facility/unit		**Satellite clinical training facility/unit. (If "Yes", which is the Primary facility/unit)**	

Name of Facility/Unit/Practice *(If Private - include name of the practice **and** the name of the clinical facility/unit being evaluated)*	

Name of Owner(s) of practice/ facility/unit	
Contact Person	
Postal Address (*Fill in all details of the clinical facility/unit being evaluated)*	
Physical Address *(of the clinical facility/unit being evaluated)*	
Telephone Number	
Fax Number	
E-mail address	

4.2 Staffing numbers at the clinical facility/unit being evaluated:

	Qualified professionals		**Current students (if relevant)**	
	No. of posts available	**No. of posts filled**	**No. of positions available**	**No. of positions filled**
Graduate Clinical Technologists				
Clinical Technologists				
Medical Specialists				
Nursing Staff				
Other				

Please provide the following information in respect of all professional staff at the clinical facility/unit being evaluated (these details may be attached as an addendum)

Surname and initials	**HPCSA Registration No**	**Designation, Discipline & Highest Qualification** *(e.g. Senior, Cardiology, BTech: Clin Tech)*

4.3 Provide a list of the range of examinations/ procedures/treatments performed and, patient statistics per month (for the past 12 months), as well as a list of the range of equipment/ devices available in the clinical facility/unit being evaluated. (*Please **attach these lists to this application form.** Indicate whether learners observe the operation of equipment/ assist with operation of equipment or operate equipment independently but under supervision)*

4.4 Will students rotate to other clinical facilities/units? If so, please specify name of facility/unit, address, type of work done in these clinical facilities/units and reason why these other facilities/units are used.

4.5 Proposed annual intake of students at this facility: (indicate numbers per levels e.g. 6 at 1st year level, 10 at 2nd year level etc.). Also state the maximum number this clinical facility/unit could have present in the facility/unit at any one time – i.e. when all learners are at WIL (not at campus).

4.6 Indicate the proposed ratio of learners versus current qualified Clinical Technology staff in this facility/unit:

Learner : Qualified =

4.7 Number of learners currently being trained in this clinical facility/unit.

4.8 Number of learners trained in the last five years in this clinical facility/unit.

4.9 Patient populations in this clinical facility/unit. Please circle the correct response.

Adult – Yes / No; Geriatric – Yes / No; Neonatal – Yes / No; Paediatric – Yes / No

5. SUPERVISION AND CLINICAL TRAINING

5.1 Name, rank and qualification/s of the professional in the clinical facility/unit who is primarily responsible for learner management, supervision and co-ordination:

5.2 Briefly describe arrangements for the supervision of learners in all workstations (including mechanisms for verifying and confirming that work produced by learners has been checked and signed by an appropriate professional):

5.3 Briefly describe formal arrangements for monitoring the attendance and formative clinical and professional/ethical development of learners by HEI and clinical facility/unit (Include details on

the use of log books, attendance registers, duty rosters, ethical and professional guidelines, relevant medico legal policies etc.):

5.4 Briefly describe formal arrangements for the summative assessment of learners for clinical competence. (Please also supply details, including names of assessors, number and types of assessments done annually and method used to assess):

5.5 Briefly describe any programme/s for demonstration and clinical instruction? (Include example of the programme – e.g. weekly tutorials, as stipulated in the clinical manual or study guide etc.):

5.6 Person(s) responsible for clinical instruction and assessment. Supply details of these persons' name/s, qualifications and clinical experience:

6. MANAGEMENT OF CLINICAL TRAINING

6.1 Briefly describe the mechanism of liaison between the radiography HEI and the clinical training facility/unit. (Include details of any Advisory Committees and/or other meetings):

6.2 Explain the responsibility chain in place for the general occupational safety and protection of the learner in the clinical situation (include details of procedures for any type of injuries on duty):

6.3 Explain the responsibility chain in place for disciplinary issues involving the learner in the clinical situation (include details of procedure to be followed and how this will be communicated to the HEI):

6.5 Explain the management of learner issues such as attendance, vacation leave, sick leave, study leave, pregnancy/maternity leave, contracts/memorandum of understanding (MOU). (attach samples of any contracts or MOUs to this application form):

We (the Higher Education Institution) accept that this application will be dealt with during a meeting of the Education, Training and Registration Committee of the Professional Board provided the application is submitted at least 30 days prior to the meeting.

The application should be submitted to the Committee Coordinator at least 30 days prior to the date of the meeting. Note: any forms that are not correctly completed, or do not contain all the required documentation, will be returned to the applicant. This may result in lengthy delays.

_____

SIGNED (On behalf of the Higher Educational Institution)

University stamp

_____

NAME (Please print)

_____

DESIGNATION

DATE:_____

To be completed by the Clinical Training Facility/Unit:
We undertake, on behalf of the Higher Education Institution, to perform clinical training and supervision according to all the requirements of the RCT Professional Board.

_____

SIGNED (On behalf of the Clinical Training Facility/Unit)

_____

NAME (Please print)

_____ _____

DESIGNATION: **DATE:**

The duly compiled application is to be submitted to:

The Committee Coordinator
Professional Board for Radiography and Clinical Technology
HPCSA
P O Box 205
PRETORIA
0001
Tel. No: 012 338 9403
Tele fax: 012 338 9403
Email: NhlanhlaM@hpcsa.co.za