



Medical Board of Queensland

INTERNSHIP REPORT (Section 92 Medical Practitioners Registration Act 2001)

Intern Name: *(Print)*.....

Hospital:

Date of Appointment:

Date of Completion:

This form is to be completed by the Director of Clinical Training (DCT) at the completion of internship. It is the responsibility of the DCT to ensure that information provided to the Medical Board of Queensland is not false and misleading.

THIS FORM IS TO BE RETURNED WITHIN 14 DAYS OF RECEIPT OF NOTICE FROM THE MEDICAL BOARD

Record of Internship:-

Unit/Department Rotation	Core (C) Elective (E)	Hospital	Start Date	End Date	Full time (F) or Part time (P)	Number of Weeks (*FTE)	End of Term Progress Satisfactory (S) Unsatisfactory (U)
Annual Leave Taken:							
Total No. of Weeks:							

Recommend removal of internship conditions by the Medical Board of Queensland: *(Insert X)* YES

NO

PLEASE ATTACH REPORT:

- a) *if a term has been assessed as "Unsatisfactory", attaching details of the Improving Performance Action Plan, its implementation, and outcome(s).*
- b) *if the removal of internship conditions is not recommended, outlining why this decision has been made. The report should include recommendations to the Medical Board regarding the amount of time and type of further experience required.*

I certify that the abovementioned Doctor has served as an intern inHospital (s) for a period or periods amounting to a total of 52 weeks (*FTE), and that the information provided is true and correct.

Print Name:.....Position.....Signature:..... Date:...../...../.....

DCT
(Primary allocation hospital)

*FTE = Full time equivalent