



SKIN CANCER COLLEGE of  
AUSTRALIA & NEW ZEALAND

## APPLICATION FOR FELLOWSHIP

Please complete all sections.

Do **not** send originals of course certificates.

Please send certified copies of certificates that have been endorsed by a Justice of the Peace or Solicitor as being true copies.

Attach the copies at the end of the application.

Post the completed application to: **The Chief Censor SCCANZ, Dr Paul Fishburn  
PO Box 430 Mosman, NSW 2088**

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ PCode: \_\_\_\_\_ Country: \_\_\_\_\_

Telephones: Home \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Current Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ PCode: \_\_\_\_\_ Country: \_\_\_\_\_

Telephone: \_\_\_\_\_ Practice Principal: \_\_\_\_\_

Type of practice (Group, solo, skin cancer only, GP etc) \_\_\_\_\_

Number of sessions (3.5 hours) per week \_\_\_\_\_

Intern Year: \_\_\_\_\_ Hospital \_\_\_\_\_

Medical Registration Number \_\_\_\_\_ Date first Registered: \_\_\_\_\_

Registering Body \_\_\_\_\_

*(attach certified copy of current certificate of registration)*

Fellowship:

College: \_\_\_\_\_ Date of fellowship: \_\_\_\_\_

*(attach copy of current fellowship membership)*

Please supply the following details for practices that you have worked in over the past 3-6 years:  
Past 3 years is required if you have worked full-time in skin cancer practice, 6 years if you have worked part-time in skin cancer practice - see Fellowship details for more information.  
The nominated referee can be any person who may be contacted via telephone to verify your work, eg another doctor, nurse, practice manager etc. Attach further details if more than three practices.

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Practice Principal: \_\_\_\_\_

Type of practice (Group, solo, skin only, GP etc) \_\_\_\_\_

Number of sessions (3.5 hours) per week \_\_\_\_\_

Date Commenced \_\_\_\_\_ to \_\_\_\_\_

Name, position held and contact details of referee for verification

\_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Practice Principal: \_\_\_\_\_

Type of practice (Group, solo, skin only, GP etc) \_\_\_\_\_

Number of sessions (3.5 hours) per week \_\_\_\_\_

Date Commenced \_\_\_\_\_ to \_\_\_\_\_

Name, position held and contact details of referee for verification

\_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Practice Principal: \_\_\_\_\_

Type of practice (Group, solo, skin only, GP etc) \_\_\_\_\_

Number of sessions (3.5 hours) per week \_\_\_\_\_

Date Commenced \_\_\_\_\_ to \_\_\_\_\_

Name, position held and contact details of referee for verification

\_\_\_\_\_

Undergraduate Education (*attach certified copy of certificates*):

Course: \_\_\_\_\_ University: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Course: \_\_\_\_\_ University: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Postgraduate Education (*attach certified copy of certificates*):

Course: \_\_\_\_\_ University: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Course: \_\_\_\_\_ University: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Course: \_\_\_\_\_ University: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Please indicate which of the following courses have been completed:

(*attach certified copies of certificates*)

SCCA Accreditation Certificate  Yes  No

UQ Masters Medicine (Skin Cancer)  Yes  No

Diploma Practical Dermatology (Wales)  Yes  No

SCCA Dermoscopy Masterclass  Yes  No

SCCA Surgery Masterclass  Yes  No

Other Skin-related courses (*please list and provide certified copy of certificates*):

\_\_\_\_\_  
\_\_\_\_\_

Please indicate which of the following activities have been completed:

Photographic Log  Yes  No

Surgical Log  Yes  No

Do you wish to submit a major research publication or other dermatology related activity in lieu of the academic requirements for general dermatology?

Yes  No

(*If Yes, please supply details as appendix to application*)

**I hereby apply for Fellowship of the Skin Cancer College of Australia and New Zealand and warrant that the details contained on this application are true and complete. I hereby authorise the College and its representatives to verify the information that I have provided on this application by contacting the relevant referees, medical boards, universities, hospitals and other nominated bodies, organisations or companies on this application.**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_