MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF

ZIMBABWE



SENIOR REGISTRAR LOGBOOK

FOR

GENERAL SURGERY

Please not that out patients departments and calls are a requirement

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Promoting the health of the population of Zimbabwe through guiding the medical and dental profession

Preamble

As a regulator Council has a statutory responsibility of assisting in the promotion of the health of the Zimbabwean public by ensuring high standards of medical education and practice.

The Council has a duty to ensure that the public of Zimbabwe receives quality care. The following guidelines have been developed to guide recently qualified Specialists both locally and abroad seeking specialist registration with the Council.

Requirements for Specialist Registration

Recently qualified practitioners Masters in Medicine (M Meds) or any approved specialist qualification by the Council upon successful completion of their specialist degree programmes are required to undertake 12 months Senior Registrar (SR) supervised practice in an approved teaching Designated Health Institution by the Council. The Senior Registrar programme is an accredited year of training intended to broaden both clinical acumen and knowledge base with a view of preparing for autonomous practice as a Consultant. Thus each Specialty has prescribed for itself areas, with Council input and approval, a set of generic and specific competencies that it feels forms a sound basis for lifelong development and practice as a safe Consultant.

In this regard, a SR is mandated to fulfill the requirements of their respective log book.

This must be duly signed by the respective supervising Consultant and submitted to the Council together with two 6 monthly reports from and signed by the respective Clinical Director and two supervising Consultants from their respective Specialty.

Where not specified in the logbook, a SR must show evidence of:

- 1) Participation in ongoing regular unit meetings(pathology, radiology, oncology etc)
- 2) Active in regular departmental audit meetings,
- 3) Active in clinical research and teaching activities.
- 4) At least 5 supervised clinical contact sessions a week, while optimally having no more than 20 percent unsupervised work load(surgical disciplines to have one independent list/week)

Personal Attributes	Strengths	Areas Of Improvement	Score
1. Presentation		•	
Personal/physical appearance			
2. Communication			
Patient, relatives and any other interested parties.			
Effective verbal skills. Present ideas and information concisely.			
Inspires confidence in colleagues. Keeps others well informed etc			
Interpersonal relations			
Work colleagues and superiors			
3. Management			
Planning and Organization			
Sets goals and priorities. Plans ahead and utilizes resources			
effectively. Ability to meet deadlines and monitor tasks.			
encetivery. Ability to ineet deadlines and monitor tasks.			
4. Judgement			
Considers pros and cons before making decisions. Considers			
risks. Considers impact of decisions and seeks advice.			
risks. Considers impact of decisions and seeks advice.			
5. Leadership			
Effectively manages situations and implements changes when			
required. Motivates, coordinates, guides and develops			
subordinates through actions and attitudes.			
6. Ethics			
Observance of both the patient's and the doctor's rights.			
Considers the ethical impact of decisions. Demonstrates actions			
and attitudes of integrity.			
7. Reliability			
Can achieve goals without supervision. Dependable and			
trustworthy.			
8. Quality of Work			
Achieves high quality of work that meets requirements of the job.			
9. Quantity of Work			
Achieves or exceeds the standard amount of work expected on			
the job.			
10. Initiative			
A self starter. Provides solutions to problems.			
11. Cooperation			
Willingness to work with others as a team member			
12. Assessment by other disciplines			
Professional conduct, reliability and quality of work.			
13. Participation in clinical audit, clinical governance and			
Continuous Professional Development			
14. Teaching			
Junior medical and dental staff. Nurses and other health			
professionals.			
		+	
15. Research			
Participation in ongoing research.			
16. Others Score 1 – 5 : 1 is the worst score and 5 is the best score. Meet can	didata quartarle a	nd discuss atransities	and areas of

Score 1-5:1 is the worst score and 5 is the best score. Meet candidate quarterly and discuss strengths and areas of improvement. Consolidate with rating from other departments for overall

OVERALL PROFESSIONAL/CLINICAL COMPETENCE:									
Score:	1	2	3	4	5	6	7	8	9
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Score:	1	2	3	4	5	6	7	8	9
Comment									
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Score:	1	2	3	4	5	6	7	8	9
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Is there any c	oncer	n abou	ıt honesty an	d inte	grity:	YES		NO	
Comment									

AUDIT: covering at least two audits during the SR year (one in each six months)									
Score:	1	2	3	4	5	6	7	8	9
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Score:	1	2	3	4	5	6	7	8	9
Attitude to P	atient	s							
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GENERAL SURGERY SENIOR REGISTRAR LOGBOOK

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12. Block dissection of	f the groin	At least 2
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13. Operation for intes	stinal fistula	At least 3	
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14. Sphincter repair	At least 1
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15. Emergency hernia	repair	At least 10
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16. Cholecystectomy(laparoscopic)	At least 3
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Hospital Number	
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Surgeon	
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Supervisor's Signature		
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Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
Supervisor's Signature		
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Signed		date
17. Cholecystectomy	(open)	At least 3
Date of assessment:		
Name of assessor:		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		

Supervisor's Signature		
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Surgeon		
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Signed		date
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40	tttdesse	At last P
18. Laparotomy for ab	odominai injury	At least 5
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Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		

Supervisor's Signature		
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Surgeon		
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Hospital Number	
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19. Laparotomy for perform	ated colon At least 1
Date of assessment:	
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Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon Assistant	

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Surgeon Assistant		
Supervisor's Signature		
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20. Laparotomy for pe	erforated peptic ulcer At leas	t 2
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Date of assessment:		
Name of assessor:		
Name of Patient		
Hospital Number		
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Surgeon		
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Name of Patient		
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Surgeon		
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Signed 21. Laparotomy for po	st operative complicat	ions At least 3
Date of assessment:		
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Name of Patient		
Hospital Number		
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Surgeon		
Assistant		
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Name of Patient	
Hospital Number	
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22. Laparotomy for small bowel obstruction	At least 5
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
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Hospital Number	
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Supervisor's Signature	

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23.	Operation for ruptured liver	At least 1
Date o	of assessment:	
Name	of assessor:	
Nam	e of Patient	
Hosp	pital Number	
Date		
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	e of Patient	
Hosp	oital Number	
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24.	Splenectomy for trauma	At least 3
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Date (of assessment:	
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25. Acute anorectal se	epsis	At least 10
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26.	Embolectomy	At least 1
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Nam	ne of Patient	
Hos	pital Number	
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27.	Fasciotomy	At least 3
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	pital Number	
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Name of Patient	
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Surgeon	
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Date of assessment:	
Date of assessment.	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
28. Rectal Injuries	At least 1
Data of accounts	
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supe	ervisor's Signature	
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	oital Number	
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29.	Tracheostomy	At least 3
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Surgeon	
Assistant	
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30. Laparascopy in acute emergencies	At least 2
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Name of assessor:	
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Hospital Number	
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Surgeon	
Assistant	

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31. Thyroidectomy	At least 3
Date of assessment:	
Date of assessment.	
Name of assessor:	
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Hospital Number	
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Surgeon	
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Hospital Number	
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Surgeon	
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32. Parotidectomy	At least 1
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Surgeon Assistant	

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Hospital Number	
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Surgeon	
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33. Lanarosconic chol	ecystectomy – (open cholangiogram) At least 2
33. Laparoscopic chol	ecystectomy – (open cholangiogram) At least 2
33. Laparoscopic chol Date of assessment:	ecystectomy — (open cholangiogram) At least 2
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	ecystectomy — (open cholangiogram) At least 2
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Date of assessment: Name of assessor: Name of Patient Hospital Number Date Surgeon Assistant	ecystectomy — (open cholangiogram) At least 2
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34.	Laparoscopic herr	ia renair		At least 2
34.	Lapai oscopic nen	на геран		At least 2
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35.	Diagnostic Lapara	SCODY		At least 1
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Name of assessor:		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
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36. Laparoscopic appe	endicectomy	At least 2
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Date of assessment:		
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Name of assessor:		
Name of assessor:		
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37.	Orchidonovy	At least 5
3/.	Orchidopexy	At least 5
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Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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38. Paediatric herniotomy Date of assessment:	At least 10
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

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Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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38.	Pyloromyotomy		At least 2
Date	of assessment:		
Name	of assessor:		
Nam	e of Patient		
Hosp	oital Number		
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	ervisor's Signature		
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39.	Surgical Reductio	n of intussusception	At least 5
Date	of assessment:		
Name	of assessor:		
Nam	e of Patient		
	oital Number		
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Surgeon	
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Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Signed	
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed		date	date	
40.	Repair of incarcerated ingu	uinal hernia	At least 5	
Date o	of assessment:			
Name	of assessor:			
Nam	e of Patient			
Hosp	oital Number			
Date	:			
Surg	eon			
Assis				
Supe	ervisor's Signature			
Signe	d	date		
Date o	of assessment:			
Name	of assessor:			
Nam	e of Patient			
Hosp	oital Number			
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Date o	of assessment:			
Name	of assessor:			
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Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
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Surgeon	
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Date of assessment:	
Date of assessment.	
Name of assessor:	
Name of assessor.	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Supervisor o Signatar o	
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Signed	date
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41. Thyroglossal cystectomy	(conditional)
TI. Illylogiossal cysteetomy	(conditional)
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supervisor's Signature		
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Signed		date
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Date of assessment:		
Name of account		
Name of assessor:		
Name of Dationt		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
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Signed		date
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Date of assessment:		
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Name of assessor:		
Name of Dations		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
Signed		date
42. Roux loop constru	ation.	At least 3
42. Roux loop constru	Ction	At least 5
Date of assessment:		
Date Of assessifient.		
Name of assessor:		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		

Supervisor's Signature	
Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
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Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
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43. Biliary bypass	At least 5
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supervisor's Signature		
Signed		date
Date of assessment:		
Name of assessor:		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
Signed		date
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Date of assessment:		
Name of assessor:		
nume of assessor.		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
Supervisor's Signature		
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Date of assessment:		
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Name of assessor:		
Name of assessor.		
Name of Patient	<u> </u>	
Hospital Number		
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Supervisor's Signature		
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Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
44. Gastrectomy	At least 5
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Date of assessment: Name of assessor:	
Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	
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Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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Data of accounts	
Date of assessment:	
Name of assessor:	
Name of assessor.	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Data of accomments	
Date of assessment:	
Name of assessor:	
Name of Dations	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant Supervisor's Signature	
Supervisor's Signature	

Signe	d	date	
45.	Open cholecystectomy – explora	ation of CBD At least 2	
Date	of assessment:		
Name	e of assessor:		
Nam	ne of Patient		
	pital Number		_
Date			
Surg	jeon		
	stant		
	ervisor's Signature		
Signe	d	date	
46.	Drainage of pancreatic pseudocy	yst At least 1	
Dato	of assessment:		
Date	or assessment.		
Name	e of assessor:		
Nam	ne of Patient		
	pital Number		
Date			_
Surg			_
	stant		_
	ervisor's Signature		_
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Signe	d	date	
47.	Segmental liver resection	At least 1	
Date	of assessment:		
Date	or assessment.		
Name	e of assessor:		
Nam	ne of Patient		
	pital Number		_
Date			_
Surg			
	stant		_

Supervisor's Signature	
Signed	date
48. Above knee ampu	tation At least 5
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Date of assessment:	
Date of assessment.	
Name of assessor:	
Name of assessor.	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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Signed	date
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Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
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Signed	date
Date of assessment:	
Date of assessment.	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Signed	date
47. Long saphrenous varices	At least 1
47. Long sapinenous varices	At least 1
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supe	rvisor's Signature		
Signed	d	date	
48.	Below knee ampu	tation At least 5	
Date o	of assessment:		
Name	of assessor:		
Nam	e of Patient		
Hosp	ital Number		
Date			
Surg	eon		
Assis	tant		
Supe	rvisor's Signature		
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Date o	of assessment:		
Name	of assessor:		
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Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	date
49. Haemorrhoidectomy	At least 3
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
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Surgeon	

Supervisor's Signature		
Signed		date
Date of assessment:		
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Name of Patient		
Hospital Number		
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Surgeon		
Assistant		
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Date of assessment:		
Name of assessor:		
Name of Patient		
Hospital Number		
Date		
Surgeon		
Assistant		
Supervisor's Signature		
Supervisor's Signature		
Signed		date
Signed		uate
50. Fissurectomy in A	no	At least 3
50. Fissurectomy in A	110	At least 5
Date of assessment:		
Date Of assessment:		
Name of assessor:		
Name of assessor:		
Name of Dations		
Name of Patient		
Hospital Number		
Date		
Surgeon		
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Supervisor's Signature	
Signed	 date
Date of assessment:	
Name of assessor:	
Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	
Signed	 date
Data of accounts	
Date of assessment:	
Name of assessor:	
Name of assessor.	
Name of Patient	
Hospital Number	
Date	
Surgeon Assistant	
Supervisor's Signature	
Supervisor's Signature	
Signed	date
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IF THERE ARE ANY UNFULFILLED AREAS, THE CHAIRPERSON OF DEPARTMENT SHOULD PROVIDE JUSTIFICATION. (Because of the unstable operating environment for surgery in public institutions, mentors should be tracking their mentees and help them to supplement deficiencies with private practice attachments (structured) as well as electives and observatories at high volume facilities).

Recommendation by the Supervising Consultant (please print name & stamp)
Eligible for Registration
Not Eligible for registration
Recommendation by the Coordinator/Head of Unit (where applicable)
Eligible for Registration
Not Eligible for registration

Overall Recommendation by the Chairperson o	of Department (please print name & stamp)
Eligible for Registration	
Not Eligible for registration	
Recommendation by the Association (<i>please</i> µ	orint name & stamp)
Eligible for Registration	
Not Eligible for registration	
PLEASE GIVE REASONS IF THERE IS A NEGATIVE	E REPORT
COMMENTS BY THE SENIOR REGISTRAR	
SIGNATURE:	DATE: