MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF

ZIMBABWE

SENIOR REGISTRAR LOGBOOK

FOR

GENERAL SURGERY

Please not that out patients departments and calls are a requirement

PERSONAL DETAILS

SURNAME.....

FORENAMES..... **(BLOCK LETTERS)**

MDPCZ REGISTRATION NUMBER:.....

DATE OF BIRTH .....
(DD/MM/YY)

Registered address

.....

.....

EMAIL ADDRESS.....

Date of Commencing SR supervised Training .....

Name of training Institution .....

Institutions & Periods/Dates

1 .....

2 .....

3 .....

4 .....

Date of Assessment.....

Names of Assessors: Dr.....

Designation.....

DR.....

Designation.....

I certify that I have checked and verified this Logbook

.....

Date..... **Dean of** .....

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.**			
4. **Judgement** **Considers pros and cons before making decisions. Considers 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 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**

Attendance to Consults: Expeditiously and appropriately attends to consults from other specialties and liaises with the consultant.									
Score:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Comment									
Leadership: takes responsibility of own action and action of the team. Takes lead in ward rounds,(posttake and at least two business rounds/week) Organizing regular ward meetings and Participation in committees at hospital and/or national level. Takes initiative to correct any management deficits that may affect team effectiveness and patient outcomes.									
Score:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Comment									
Team Player: Accepts appropriate responsibility, Reliable, Supportive and approachable.									
Score:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Comment									
Honesty and Integrity:									
Is there any concern about honesty and integrity: **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
Comment
Professional Interactions and Integrity
Attitude to colleagues **Score: 1 2 3 4 5 6 7 8 9**
Attitude to Junior staff **Score: 1 2 3 4 5 6 7 8 9**
Attitude to Nursing staff **Score: 1 2 3 4 5 6 7 8 9**
Attitude to Patients **Score: 1 2 3 4 5 6 7 8 9**
Comment

GENERAL SURGERY SENIOR REGISTRAR LOGBOOK

1. Mastectomy: At least 6

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	

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Date of assessment:

Name of assessor:

Name of Patient	
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Date	
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Assistant	
Supervisor's Signature	

Signed …….. date ……

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Surgeon	
Assistant	

Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date ……

Date of assessment:

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Name of Patient	
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Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date ……

2. Anterior resection of rectum At least 2

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	

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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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3. Fistula in ano At least 2

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	

Assistant	
Supervisor's Signature	

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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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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date ……

4. Colostomy At least 10

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	

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Supervisor's Signature	

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Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date ……

5. Hartmanns procedure At least 5

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
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Assistant	
Supervisor's Signature	

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Assistant	
Supervisor's Signature	

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Date of assessment:

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Name of Patient	
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Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date …….

6 Incisional hernia repair 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	

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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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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
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Assistant	
Supervisor's Signature	

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Supervisor's Signature	

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Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …….. date …….

7. Hemicolectomy **At least 5**

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	

Assistant	
Supervisor's Signature	

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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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Date of assessment:

Name of assessor:

Name of Patient	
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Supervisor's Signature	

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Name of assessor:

Name of Patient	
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Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

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Date	
Surgeon	
Assistant	
Supervisor's Signature	

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8. Repair of recurrent groin hernia At least 1

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed ……. date …….

9. Small bowel resection At least 10

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
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Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
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Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
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Supervisor's Signature	

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Name of Patient	
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Date of assessment:

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Name of Patient	
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Surgeon	
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Surgeon	
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Supervisor's Signature	

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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 ……

10. AP resection of rectum **At least 2**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

11. Closure of Hartmanns **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 ……

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 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 ……

12. Block dissection of the groin At least 2

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

13. Operation for intestinal fistula At least 3

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

14. Sphincter repair **At least 1**

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 ……

15. Emergency hernia repair At least 10

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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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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Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

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Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
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Supervisor's Signature	

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Name of Patient	
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Date	
Surgeon	
Assistant	
Supervisor's Signature	

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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 ……

16. Cholecystectomy(laparoscopic) At least 3

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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	

Signed …….. date ……

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 ……

18. Laparotomy for abdominal injury 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 ……

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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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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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 ……

19. Laparotomy for perforated colon At least 1

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 ……

20. Laparotomy for perforated peptic ulcer At least 2

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

21. Laparotomy for post operative complications At least 3

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

22. Laparotomy for small bowel obstruction 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	

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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 ……

23. Operation for ruptured liver **At least 1**

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 ……

24. Splenectomy for trauma **At least 3**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

25. Acute anorectal sepsis At least 10

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 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 ……

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	

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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 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 ……

26. Embolectomy **At least 1**

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 ……

27. Fasciotomy **At least 3**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

28. Rectal Injuries **At least 1**

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 ……

29. Tracheostomy **At least 3**

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 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 ……

30. Laparascopy in acute emergencies At least 2

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

31. Thyroidectomy **At least 3**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

32. Parotidectomy **At least 1**

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 ……

33. Laparoscopic cholecystectomy – (open cholangiogram) At least 2

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 ……

34. Laparoscopic hernia repair **At least 2**

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 ……

35. Diagnostic Laparascopy **At least 1**

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 ……

36. Laparoscopic appendicectomy At least 2

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 ……

37. Orchidopexy **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 ……

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

38. Paediatric herniotomy **At least 10**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Name of assessor:

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Assistant	
Supervisor's Signature	

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Supervisor's Signature	

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Surgeon	
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Supervisor's Signature	

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Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

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Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

38. Pyloromyotomy **At least 2**

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 ……

39. Surgical Reduction of intussusception **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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Supervisor's Signature	

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Supervisor's Signature	

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Supervisor's Signature	

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Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

40. Repair of incarcerated inguinal hernia At least 5

Date of assessment:

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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	

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Supervisor's Signature	

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Hospital Number	
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Assistant	
Supervisor's Signature	

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Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

41. Thyroglossal cystectomy (conditional)

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

42. Roux loop construction **At least 3**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

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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Name of Patient	
Hospital Number	
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Surgeon	
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Supervisor's Signature	

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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 ……

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	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Assistant	
Supervisor's Signature	

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Name of Patient	
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Date	
Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

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Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

45. Open cholecystectomy – exploration of CBD At least 2

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

46. Drainage of pancreatic pseudocyst At least 1

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

47. Segmental liver resection At least 1

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supervisor's Signature	

Signed …… date ……

48. Above knee amputation 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	

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Date of assessment:

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Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

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Surgeon	
Assistant	
Supervisor's Signature	

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Date of assessment:

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Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

47. Long saphrenous varices **At least 1**

Date of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	

Supervisor's Signature	

Signed …… date ……

48. Below knee amputation 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:

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Name of Patient	
Hospital Number	
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Surgeon	
Assistant	
Supervisor's Signature	

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Supervisor's Signature	

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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	
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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

50. Fissurectomy in Ano **At least 3**

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 of assessment:

Name of assessor:

Name of Patient	
Hospital Number	
Date	
Surgeon	
Assistant	
Supervisor's Signature	

Signed …… date ……

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 of Department (*please print name & stamp)*

Eligible for Registration .....

Not Eligible for registration .....

Recommendation by the Association (*please print name & stamp)*

Eligible for Registration .....

Not Eligible for registration .....

PLEASE GIVE REASONS IF THERE IS A NEGATIVE REPORT

.....

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.....

.....

COMMENTS BY THE SENIOR REGISTRAR

.....

.....

SIGNATURE:..... **DATE:.....**