MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF

ZIMBABWE



SENIOR REGISTRAR LOGBOOK

FOR

GENERAL SURGERY

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

GENERIC FORMAT FOR PRE-REGISTRATION SENIOR REGISTRAR IN GENERAL SURGERY

|  |  |  |  |
| --- | --- | --- | --- |
| Personal Attributes | Strengths | Areas Of Improvement | Score |
| 1. Presentation   Personal/physical appearance |  |  |  |
| 1. 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 |  |  |  |
| 1. Management   Planning and Organization  Sets goals and priorities. Plans ahead and utilizes resources effectively. Ability to meet deadlines and monitor tasks. |  |  |  |
| 1. Judgement   Considers pros and cons before making decisions. Considers risks. Considers impact of decisions and seeks advice. |  |  |  |
| 1. Leadership   Effectively manages situations and implements changes when required. Motivates, coordinates, guides and develops subordinates through actions and attitudes. |  |  |  |
| 1. Ethics   Observance of both the patient’s and the doctor’s rights. Considers the ethical impact of decisions. Demonstrates actions and attitudes of integrity. |  |  |  |
| 1. Reliability   Can achieve goals without supervision. Dependable and trustworthy. |  |  |  |
| 1. Quality of Work   Achieves high quality of work that meets requirements of the job. |  |  |  |
| 1. Quantity of Work   Achieves or exceeds the standard amount of work expected on the job. |  |  |  |
| 1. Initiative   A self starter. Provides solutions to problems. |  |  |  |
| 1. Cooperation   Willingness to work with others as a team member |  |  |  |
| 1. Assessment by other disciplines   Professional conduct, reliability and quality of work. |  |  |  |
| 1. Participation in clinical audit, clinical governance and Continuous Professional Development |  |  |  |
| 1. Teaching   Junior medical and dental staff. Nurses and other health professionals. |  |  |  |
| 1. Research   Participation in ongoing research. |  |  |  |
| 1. 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

GENERAL SURGERY SENIOR REGISTRAR LOGBOOK

1. Mastectomy: At least 10

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Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Date of assessment:

Name of assessor:

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| 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 |  |
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| Supervisor’s Signature |  |
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| Name of Patient |  |
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| Date |  |
| Surgeon |  |
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| Name of Patient |  |
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| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
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| Date |  |
| Surgeon |  |
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| Supervisor’s Signature |  |
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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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2. Anterior resection of rectum At least 2

Date of assessment:

Name of assessor:

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| 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 |  |
| 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:

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| 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:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| 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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4. Colostomy At least 10

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
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| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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5. Hartmanns procedure At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
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| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Surgeon |  |
| Assistant |  |
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| Name of Patient |  |
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| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed …………………………………………………….. date …………………………………………………………….

6 Incisional hernia repair At least 5

Date of assessment:

Name of assessor:

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| 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 |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
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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:

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| Name of Patient |  |
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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 |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Assistant |  |
| Supervisor’s Signature |  |
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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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7. Hemicolectomy At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Date of assessment:

Name of assessor:

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| Name of Patient |  |
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| Surgeon |  |
| Assistant |  |
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| Name of Patient |  |
| Hospital Number |  |
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| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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| Assistant |  |
| Supervisor’s Signature |  |
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Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| 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:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ……………………………………………………. date …………………………………………………………….

9. Small bowel resection At least 10

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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10. AP resection of rectum At least 2

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ……………………………………………… date …………………………………………………………………

11. Closure of Hartmanns At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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12. Block dissection of the groin At least 2

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Date of assessment:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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13. Operation for intestinal fistula At least 3

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ……………………………………………………….. date …………………………………………………………….

14. Sphincter repair At least 1

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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15. Emergency hernia repair At least 10

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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16. Emergency cholecystectomy(laparoscopic) At least 3

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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17. Emergency cholecystectomy (open) At least 1

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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18. Laparotomy for abdominal injury At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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19. Laparotomy for large bowel obstruction At least 10

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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20. Laparotomy for perforated colon At least 1

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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21. Laparotomy for perforated peptic ulcer At least 2

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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22. Laparotomy for post operative complications At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

23. Laparotomy for small bowel obstruction At least 5

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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24. Operation for ruptured liver At least 1

Date of assessment:

Name of assessor:

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| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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25. Splenectomy for trauma At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

26. 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 ……………………………………………………………

27. Embolectomy At least 1

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

28. Fasciotomy At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

29. Rectal Injuries At least 1

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

30. Tracheostomy At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

31. Laparascopy in acute emergencies At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

32. Thyroidectomy At least 3

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

33. Parotidectomy At least 2

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

34. Submandibular gland excision At least 2

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

35. Laparoscopic cholecystectomy At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

36. Laparoscopic cholecystectomy – operative cholangiogram At least 2

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

37. 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 ……………………………………………………………

38. Diagnostic Laparascopy At least 1

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

39. Laparoscopic biopsy At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

40. Laparoscopic adhesiolysis At least 2

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

41. Laparoscopic appendicectomy At least 2

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

42. Orchidopexy At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

43. Paediatric herniotomy At least 10

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

44. Pyloromyotomy At least 2

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
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Signed ………………………………………………… date ……………………………………………………………

45. 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 ……………………………………………………………

46. Repair of incarcerated inguinal hernia At least 5

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

47. Thyroglossal cystectomy At least 2

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

48. 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 ……………………………………………………………

49. Biliary bypass At least 5

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

50. Gastrectomy At least 5

Date of assessment:

Name of assessor:

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| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

51. 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 ……………………………………………………………

52. Drainage of pancreatic pseudocyst At least 3

Date of assessment:

Name of assessor:

|  |  |
| --- | --- |
| Name of Patient |  |
| Hospital Number |  |
| Date |  |
| Surgeon |  |
| Assistant |  |
| Supervisor’s Signature |  |
|  |  |

Signed ………………………………………………… date ……………………………………………………………

53. 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 ……………………………………………………………

54. 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 ……………………………………………………………

55. 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 ……………………………………………………………

56. 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 ……………………………………………………………

Overall assessment by Chairperson Department of Surgery

Registrable …………………………………………………………………………………………………………………..

Non Registrable………………………………………………………………………………………………

Recommendation by Zimbabwe Surgical Society

Registrable……………………………………………………………………………………………………

Non registrable………………………………………………………………………………………………