MEDICAL AND DENTAL PRACTITIONERS

COUNCIL OF ZIMBABWE



SENIOR REGISTRAR LOGBOOK

FOR

PAEDIATRIC SURGERY

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

GENERIC FORMAT FOR PRE-REGISTRATION SENIOR REGISTRAR IN PAEDIATRIC SURGERY

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| 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

1. HEAD AND NECK
   1. Excision Cystic Hygroma: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Other Lymphatic/Vascular Malformation: at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Periorbital Dermoid: at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex. Subcutaneous Dermoid : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Thyroidectomy : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Tracheostomy : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Thyroglossal Cyst : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Branchial Remnant : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Lymph Node(s) Neck: at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Sternomastoid Division For Torticollis: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Operation For MAIS: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Operation On Preauricular Sinus : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Drainage Abscess: at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Division Tongue Tie : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Minor : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. SKIN AND APPENDAGES
   1. Mastectomy For Gynaecomastia : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Skin/Subcutaneous Lesion : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Drainage Abscess : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ingrown Toenail Operation : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other : at least 2

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| Date | Nme of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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2.6 Ex Sacral Sinus / Coccygeal Pit : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. THORACIC
   1. Chest Wall Deformity Surgery : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ex Intrathoracic Tumour : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Lung Resection : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Empyema Surgery : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Non Neonatal OA : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Oesophageal Replacement : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Biopsy Intrathoracic Tumour : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Open Lung Biopsy : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Thoracotomy For Trauma : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Oesophagoscopy +/ FB, Stricture Dilation : at least 6

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Insertion Chest Tube : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Bronchoscopy flexible and Rigid : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Oesophagoscopy Rigid : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. H Fistula–Non-Neonatal : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Minor : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. ABDOMINAL
   1. Liver Resection Or Transplantation : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Liver Biopsy Open Wedge : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Biliary Atresia Surgery : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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4.4 Choledochal Cyst Surgery Or Biliary Reconstruction: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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4.5 Open Cholecystectomy : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Biliary Procedure : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Rectoplasty/PSARP : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Hirschsprung’s ~ Definitive Surgery Outside Neonatal: at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Intussusception: Enema Reduction or Pneumatic Reduction At least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Intussusception: Open Reduction at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Meckel’s Diverticulectomy : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy With Stoma Formation : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy Division Adhesions: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy, Resection, Anastomosis : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy For Major Trauma : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Closure Of Stoma : at least 6

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Splenectomy, Splenorrhaphy (Open) : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Appendicectomy (Open) : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Pyloromyotomy : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Gastrostomy Open : at least 3

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* 1. Gastrostomy Percutaneous : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Change Gastrostomy Button / Tube : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Anoplasty (Non-Neonatal) : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Rectal Prolapse Surgery : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Internal Anal Sphincterotomy: at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Anal Fistulotomy : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Rectal Biopsy Open : at least 6

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Drainage Perianal Abscess : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Flexible Lower GI Endoscopy : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. EUA, Sigmoidoscopy : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Fundoplication : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Primary Peritonitis : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Epigastric Hernia Repair : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Inguinal Herniotomy < 6 Months : at least 10

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Inguinal Herniotomy > 6 Months : at least 10

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Orchidopexy < 1 Year, Or Testis At Or Above Deep Ring : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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4.37 Orchidopexy > 1 Year : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Flexible Upper GI Endoscopy: at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Umbilical Hernia Repair : at least 10

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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4.40 Femoral Hernia Repair : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Malrotation / Volvulus (Non-Neonatal) : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Sero - Muscular Biopsies (Colon) (Open) : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ace Procedure (Open) : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major Abdominal : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Minor Abdominal : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. GENITOURINARY
   1. Nephrectomy +/-Ureterectomy : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Vesicostomy/Closure : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ureteric Anastomosis : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ureterocele Procedure : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ureteric Reimplantation : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Cystoscopy And Manipulation : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Cystoscopy: at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Bladder Exstrophy/Epispadias : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Bladder Augmentation : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Intersex - Clitoroplasty / Vaginoplasty : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Cloacal Reconstruction : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Meatotomy : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Circumcision : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Varicocele Surgery (Open) : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Scrotal Exploration For Testicular Torsion : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Scrotal Exploration - Other Cause : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Gonadectomy Intersex : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Ovarian Procedure : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Insertion / Removal Peritoneal Dialysis Catheter : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Division Labial Adhesions : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Minor (Incl EUA) : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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6. NEONATAL

* 1. Abdominal Wall Defect: Simple Amphobocele : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Abdominal Wall Defect: Complex Gastroschitisis : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Diaphragmatic Hernia Repair : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. OA / TOF Surgery : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy For NEC : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy For Malrotation / Volvulus : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparotomy For GI Atresia : at least 5

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* 1. Laparotomy For Meconium Ileus And Related Disorders : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Hirschsprung’s Definitive Surgery : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Stoma Formation /Closure : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Anoplasty : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major Neonatal Surgery (Including PDA) : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Contrast Enema For Meconium Ileus : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Neonatal Urological Procedure – Specify : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Neonatal Laparoscopy : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. MINIMAL ACCESS SURGERY
   1. Thoracoscopy Minor : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Thoracoscopy Major (Including Procedure) : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopy Diagnostic/Assisted : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Appendicectomy : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Cholecystectomy: at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Fundoplication ; at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Splenectomy : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopy For UDT 1st Stage : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopy For UDT 2nd Stage : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Other Major : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Other Minor : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Assisted Rectoplasty/PSARP : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Hirschprung’s – Definitive (Non-Neonatal) : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Gastrostomy : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic ACE Procedure : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Seromuscular Biopsy : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Gonadectomy : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Ovarian Procedure : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laparoscopic Ladd’s Procedure : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. TUMOUR SURGERY
   1. Wilms Tumour : at least 5

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Neuroblastoma -Any Site : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Rhabdomyosarcoma -Any Site : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Liver Tumour : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Gonadal Tumour : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Lymphoma Biopsy / Excision : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Sacrococcygeal Tumour Excision : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major Tumour Excision : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Tumour Biopsy : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. INTERVENTIONAL RADIOLOGY
   1. Sclerotherapy Of Lymphatic Malformation : at least 3

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Percutaneous Nephrostomy : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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1. OTHERS
   1. Central Line Insertion : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Central Line Removal : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Lymph Node Biopsy: at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Neurosurgical Major : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laceration Major : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Laceration Minor : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Vessel Reconstruction : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Removal Foreign Body : at least 1

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Major : at least 2

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Other Minor : at least 4

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| Date | Name of Patient | Hospital Number | Surgeon | Assistant | Supervisor’s Signature |
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* 1. Contrast Enema : at least 5

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

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| --- | --- | --- | --- | --- |
|  | Surgeon | Assistant | Observer | Totals |
| Maj: Min: | Maj: Min: | Maj: Min: | Maj: Min |
| 1.0 Head and Neck |  |  |  |  |
| 2.0 Skin and Appendages |  |  |  |  |
| 3.0 Thoracic |  |  |  |  |
| 4.0 Abdominal |  |  |  |  |
| 5.0 Genitourinary |  |  |  |  |
| 6.0 Neonatal |  |  |  |  |
| 7.0 Minimal Access Surgery |  |  |  |  |
| 8.0 Tumours |  |  |  |  |
| 9.0 Others |  |  |  |  |
| Interventional radiology |  |  |  |  |
| *Totals* |  |  |  |  |
|  |  |  | All cases = | |

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| Major 1 |  |  |  |  |
| Major 2 |  |  |  |  |
| Major 3 |  |  |  |  |
| Major 4 |  |  |  |  |
| Endoscopic 5 |  |  |  |  |

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**

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

IF THERE ARE ANY UNFILLED AREAS, THE CHAIRPERSON OF THE DEPARTMENT SHOULD PROVIDE JUSTIFICATION.

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

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