ANZCA
FPM

CONTINUING PROFESSIONAL DEVELOPMENT

# ANZCA and FPM CPD Program

## Patient experience survey confidentiality and CPD verification form

### CONFIDENTIALITY

Participant (specialist) name: _____

Where participant practices: _____

Administrator name: _____

Administrator role and where they work: _____

Feedback provider name (as relevant): _____

Feedback provider role and place of practice: _____

### Administrator – prior to commencement

I will undertake the role of administrator of the patient/parent experience/satisfaction survey for the purposes of the ANZCA and FPM CPD Program. After collating the results and completing the survey summary form, I will provide the summary form to the participant and the feedback provider (if relevant) listed above. I will confidentially delete both the individual patient/parent response forms and the summary form from my records.

I will maintain as confidential:

1. Individual feedback from patients/parents.
2. All information regarding the performance of the participant in this activity.

I confirm that I have read, understood and agree to the above conditions to maintain the strictest confidentiality of the information collected in this practice evaluation activity.

Signed: _____ Date: ____/____/____

### Feedback provider – prior to commencement (leave blank if no feedback provider)

I will undertake the role of feedback provider in the patient/parent experience/satisfaction survey for the purposes of the ANZCA and FPM CPD Program. After providing feedback to the participant named above, I will destroy my copy of the survey summary form.

I will maintain as confidential:

1. Responders' feedback.
2. All information regarding the performance of the participant in this activity.

I confirm that I have read, understood and agree to the above conditions to maintain the strictest confidentiality of the information collected in this practice evaluation activity.

Signed: _____ Date: ____/____/____

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## CPD VERIFICATION

### Administrator – after providing participant with summary

I confirm that in the patient experience survey process for _____

*(Participant's name)* a minimum of 15 surveys were included in the summary form provided to them.

Signed: _____ Date: ____/____/___

### Feedback provider – after completion of feedback session (leave blank if no feedback session)

I confirm that in the patient experience survey process for _____

*(Participant's name)* a feedback meeting was held.

I have confidentially destroyed my copy of the survey summary form.

Signed: _____ Date: ____/____/___