General Practice Services Committee

Participant Application Package
Maternity Care for BC (MC4BC)

Overview

Welcome to the MC4BC Participant Application Package!

This package contains a series of forms that must be completed, signed and submitted by all potential program participants. Here is a brief description of the forms included in the Application Package.

- Form 1: Applicant Contact and Background Information
  The purpose of this form is to provide MC4BC with contact and background information about the Program Applicant.

- Form 2: Applicant Learning Needs Assessment
  This purpose of this form is to help Participants assess their learning needs related to the provision of maternity care.

- Form 3: MC4BC Learning Objectives Worksheet
  Building upon learning needs identified in Form 2, the purpose of this form is to help Participants develop their MC4BC learning objectives and brainstorm training activities that will help them achieve those learning objectives.

- Form 4: MC4BC Learning Plan
  This form requires Participants to outline their detailed learning plans, including the Preceptor or Mentor they plan to work with, learning activities and learning objectives. It is recommended that Participants work with their preceptors when developing their learning plans. If Participants require support in identifying a Preceptor or Mentor, they are encouraged to contact their local Division of Family Practice or MC4BC Program Administrator for support. MC4BC maintains a roster of providers willing to support program Participants in different communities (contact the MC4BC Administrator for further information).

- Form 5: Facility Letter of Support for MC4BC Participation
  This form ensures the Participant has received approval to work at the specified facility for the purposes of MC4BC training. This form must be signed by the Health Authority approved physician leader who is responsible for recommending/confirming hospital obstetrical privileges (e.g. Chief of Medical Staff, Department Head, Division Head, etc.). Note that the Facility Letter for Support is not required for those applying to receive mentorship support only.

ALL forms must be completed, signed and submitted to the MC4BC Program Administrator.

MC4BC Administrator
Doctors of BC
115 - 1665 West Broadway, Vancouver, BC V6J 5A4 E:
gpsc.mc4bc@doctorsofbc.ca W: www.gpscbc.ca

FORM 1: APPLICANT CONTACT AND BACKGROUND INFORMATION

Collection of information: The information on this form is collected for the purposes of processing your application for funding through the MC4BC Program (a program of the General Services Practices Committee), and record keeping associated with that Program. All information you provide will be used in a manner that complies with the terms of the Freedom of Information and Protection of Privacy Act.

I. PERSONAL DATA	
First Name:	**Surname:**
Gender: ☐ Male ☐ Female ☐ Other	**MSP Payee Number:**
Email:	**Cell Phone:**
Home Phone:	**Business Phone:**
II. COLLEGE OF PHYSICIANS AND SURGEONS OF BC (CPSBC) REGISTRATION	
Date of CPSBC Registration (dd/mm/yyyy):	**CPSBC Identification Number:**
Name of Family Medicine Residency Program:	**Date of Graduation (mm/yyyy):**

III. FUNDING REQUESTED (Check all that apply)

☐ Training Stipend ☐	☐ Preceptor Stipend ☐	☐ Mentorship Stipend ☐	☐ Travel Allowance ☐	☐ Additional Educational Requirements ☐	☐ CMPA Differential ☐

Are you receiving any other funding or incentives for obstetrical training from any other source?

☐ Yes ☐ No

If yes, please list other funding or incentives:

IV. DECLARATION

I hereby declare that the information I have provided in this application is, to the best of my knowledge, correct and complete. I acknowledge that this information may be used to determine my eligibility for funding from the MC4BC Program and to determine whether I must repay any such funding if I do not complete any approved and funded training.

- I understand that making statements that are not true, or that are misleading, may be considered fraud. Fraud is against the law in Canada and reasonable suspicion of fraud may result in civil action or criminal prosecution;
- I understand that the sessional fee from my first delivery ($158.97) will be withheld until the completion of the Program;
- I agree that I will provide proof of completion of the Program by submitting a Self-Reflection Learning Activity Form to the MC4BC Administrator;
- I agree that I will use GPSC funds specifically and exclusively for enhanced obstetrical training only;
- I have divulged all other sources of obstetrical training/upgrading funding that I have received;
- I agree that I will maintain hospital privileges and obstetrical professional liability insurance to provide obstetrical services within the Province of British Columbia for a minimum of 2 years upon completion of the Program;
- I understand that I may be asked for information about the Program for evaluation purposes.

Applicant Signature:	**Applicant Name:**
Date Signed (dd/mm/yyyy):	

FORM 2: APPLICANT LEARNING NEEDS ASSESSMENT

This purpose of this needs assessment is to help Participants identify their learning needs related to the provision of maternity care.

I. GENERAL MATERNITY CARE EXPERIENCE

Please provide details about your maternity care experience to date.

MEDICAL SCHOOL	
Year of Graduation:	**Location:**
# of weeks of experience with maternity care:	**# of births attended as learner (actual or estimated):**
Other details about medical school maternity care experience:	
RESIDENCY OR INTERNSHIP	
Year of Graduation:	**Location:**
# of weeks of experience with maternity care:	**# of births attended as learner (actual or estimated):**
Other details about residency or internship maternity care experience:	
PRACTICE	
Dates involved in practice: **From (mm/yy):** **To (mm/yy):**	**Location:**
# of weeks of experience with maternity care:	**# of births attended as most responsible provider (actual or estimated):**
Other details about practice-based maternity care experience:	

FORM 2: APPLICANT LEARNING NEEDS ASSESSMENT (CONT.)

II. SYSTEMS AND RESOURCES IN COMMUNITY AND LOCAL FACILITY

Please rate your familiarity with the following maternity-related systems and resources in the local community/facility you plan to work in for MC4BC.

Learning Area	Not at all familiar	Somewhat familiar	Very familiar
Registration for in-hospital delivery.	○	○	◉
Policies regarding referral if any.	○	◉	○
Policies and processes for hospital privileges and maintenance of privileges.	○	○	◉
Policies and processes for induction of labour.	○	◉	○
Facilities for ultrasound and prenatal genetic screening, specialist referrals, Pubic Health supports, other resources.	○	○	◉
Indications for and mechanism of transfer to another facility.	○	○	○
Resources available for PN care, PP care, newborn care, breastfeeding, specialists, Public Health, special populations, PP depression, etc.	○	○	○
Understand who the team members are for various aspects of care.	○	○	○
On-call arrangements and options.	○	○	○
Work-life balance strategies used by local physicians.	○	○	○

FORM 2: APPLICANT LEARNING NEEDS ASSESSMENT (CONT.)

III. PRENATAL CARE

Please rate your competence in providing maternity care in the following areas related to prenatal care.

Learning Area	Needs significant improvement	Satisfactory; could improve	Perform with ease
Pregnancy confirmation, determining and confirming expected due date (EDD)	○	○	○
Prenatal genetic screening: tests available, timing, referral, counseling, results follow up	○	○	○
Screening in PN care: by history, ethnicity, risk factors, and physical examination	○	○	○
Lifestyle counseling in PN care	○	○	○
Routine PN visits	○	○	○
Management of requests for abortion, including referral, counseling, and follow up	○	○	○
Management of early pregnancy bleeding and miscarriage	○	○	○
Management of hypertensive disorders during pregnancy	○	○	○
Management of threatened and actual preterm labour	○	○	○
Diagnosis and management of suspected growth variations (IUGR, macrosomia)	○	○	○
Counselling and eligibility for VBAC and consent if applicable	○	○	○
Administering and interpreting TACE and Edinburgh Postpartum Depression Scale questionnaires	○	○	○
Prelabour rupture of membranes, at term and preterm	○	○	○
Screening and management of Gestational Diabetes	○	○	○
Availability of specialists at this facility and community	○	○	○
Indications for referral for Obstetrics, Internal Medicine, Anesthesia, Pediatrics, and other specialties.	○	○	○

FORM 2: APPLICANT LEARNING NEEDS ASSESSMENT (CONT.)

IV. LABOUR & BIRTH

Please rate your competence in providing maternity care in the following areas related to labour and birth.

Learning Area	Needs significant improvement	Satisfactory; could improve	Perform with ease
Management of prodromal labour	○	◉	○
Management of normal second stage	○	○	○
Analgesia options in labour: ▪ Medications and dosages ▪ Sterile water injection technique ▪ Nitrous oxide technique	○	○	○
Assessment and management of progress in labour and recognizing variations in labour	○	○	○
Management of dystocia in labour	○	○	○
Management of induction of labour	○	○	○
Management of augmentation of labour	○	○	○
Interpretation of fetal heart rate assessments ▪ Auscultation ▪ Continuous electronic fetal heart rate monitoring and indications	○	○	○
Management of shoulder dystocia	○	○	○
Conducting an in-hospital delivery (Management of stages of labour: first stage; second stage; third stage; fourth stage)	○	○	○
Promoting normal birth without interventions	○	○	○
Providing care with and without epidural	○	○	○
Performing episiotomy and indications for	○	○	○
Delivery of placenta by manual removal	○	○	○
Diagnosis and management of post-partum hemorrhage	○	○	○
Repair of 2nd degree lacerations and diagnosis of 3rd / 4th degree lacerations	○	○	○
Performing vacuum-assisted delivery	○	○	○
Indications for specialist consultation in labour	○	○	○
Examination of newborn after birth	○	○	○
Performing resuscitation of a newborn (NRP)	○	○	○

FORM 2: LEARNING NEEDS ASSESSMENT (CONT.)

V. POSTPARTUM AND NEWBORN CARE

Please rate your competence in providing maternity care in the following areas related to postpartum and newborn care.

Learning Area	Needs significant improvement	Satisfactory; could improve	Perform with ease
Post-partum care of mother, routine	○	○	◉
Diagnosis and treatment of infections: endometritis, UTI, mastitis	○	○	◉
Screening for and treatment of PP depression	○	◉	○
Follow up for complications of pregnancy and birth (i.e. PIH, GDM, PPH etc.)	○	◉	○
Discharge criteria for mother and newborn	○	◉	○
Supporting early breastfeeding: ▪ At delivery ▪ In the 1st 24 hours ▪ In the 2nd 24 hours ▪ In the 3rd day and beyond	○	◉	○
Diagnosis and treatment of breastfeeding problems	○	◉	○
Neonatal hyperbilirubinemia: testing for, interpretation, treatment	○	◉	○
Newborn Hypoglycemia - indications for testing, tests, and interpretation	○	◉	○
Neonatal withdrawal syndromes (narcotics, antipsychotics, antidepressants)	○	◉	○
Assessment of newborn weight changes and treatment of excessive wt. loss	○	○	◉
Child development in first 2 weeks	○	○	◉
Rourke Baby Record– how to use, where to find it	○	○	◉

FORM 3: MC4BC LEARNING OBJECTIVES WORKSHEET

Building upon learning needs identified in Form 2, the purpose of this worksheet is to help Participants develop their MC4BC learning objectives and brainstorm training activities that will help them achieve those learning objectives.

Learning Objectives	What activities might help you achieve your objectives?
1.	
2.	
3.	
4.	
5.	

FORM 4: MC4BC LEARNING PLAN

This purpose of this form is for participants to outline their detailed learning plans, including the Preceptor or Mentor they plan to work with, their planned activities and learning objectives. It is recommended that participants work with their Preceptors/Mentors when completing this form. If participants require support in identifying a Preceptor or Mentor, they are encouraged to contact their local Division of Family Practice or MC4BC Program Administrator for support. MC4BC maintains a roster of providers willing to take on program participants in different communities.

I. PRECEPTOR(S) OR MENTOR(S)	
Name(s):	**Clinic Location:** **Facility Location:**
II. DATES AND DURATION OF LEARNING PERIOD	
Expected Start Date:	**Expected End Date:**
III. REQUIREMENTS FOR OBSTETRICAL PRIVILEGES AT FACILITY (not required for mentorship only)	
List facility requirements and your plan to meet them (include dates):	
IV. DETAILED LEARNING PLAN: PRENATAL, POSTPARTUM & NEWBORN CARE	
Planned Activities:	
Learning Objectives:	
IV. DETAILED LEARNING PLAN: LABOUR & BIRTH	
Planned Activities:	
Expected number of births:	
Learning Objectives:	

FORM 5: FACILITY LETTER OF SUPPORT FOR MC4BC PARTICIPATION

This form should be signed by the Health Authority approved physician leader who is responsible for recommending/confirming hospital obstetrical privileges (e.g. Chief of Medical Staff, Department Head, Division Head, etc.).

The GP mentioned below (Applicant) is applying to the GPSC Maternity Care for BC (MC4BC) Program to enhance their maternity care skills and experience. A brief outline of their learning plan is outlined in Form 4 of this Application Package. If you are able to support this plan, please sign this form and return it to the Applicant.

This form does not need to be completed by those applying to receive mentorship support only.

TO BE COMPLETED BY MC4BC APPLICANT	
First Name:	**Surname:**
Name of facility:	
Name of Preceptor(s):	
Brief description of Applicant's planned learning activities:	
Planned dates for learning period. **From:**	**To:**
TO BE COMPLETED BY FACILITY	
I _____ (Print Name) support the Applicant's self-directed learning plan at this facility. I confirm that the Applicant has met the requirements and has been (or will be) granted temporary hospital privileges to provide obstetrical care during the learning period noted above.	
Signature:	
Position:	
Date Signed (dd/mm/yyyy):	