FORM 2 – CICP–PRIMARY RECREDENTIALLING PEER REVIEW FORM

The reviewer must send this form directly to office@acipc.org.au

Peer Reviewer's Name:

Peer Reviewer's Position and Organisation:

Credentialling Applicant's Name:

Date of Review:

REVIEWER STATEMENTS

For CAPS Assessment only

What is your professional relationship to the applicant?

◯ Applicant's supervisor ◯ Applicant's client ◯ Met ◯ Not Met

◯ Applicant's professional colleague ◯ Other (Specify)

How long have you known the applicant in a professional capacity? _____ (years) ◯ Met ◯ Not Met

In what capacity have you worked closely with the applicant? ◯ Met ◯ Not Met

Please acknowledge your willingness to handle all information associated with this application in confidence in accordance with College policy. ◯ Met ◯ Not Met

◯ Yes ◯ No

ELEMENT – Role and Practice

For CAPS Assessment only

Describe how the applicant's practice and role demonstrates they have maintained an active scope of practice as a Primary CICP in one of the following areas: ◯ Met ◯ Not Met

a) Specific outbreak situation; or
b) Infection control quality improvement activity; or
c) Infection control policy/procedure development/ implementation/review, or
d) Education project and activities, or
e) One or more elements of the infection control program.

Peer Reviewer Comments:

ELEMENT – Mentoring and Networking

For CAPS Assessment only

Describe how the applicant has actively engaged in networking with peers and undertaken mentoring from other colleagues including other credentialed ICPs that have resulted in their professional growth and development.

◯ Met ◯ Not Met

Peer Reviewer Comments:

OTHER PEER REVIEWERS COMMENTS