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MABEL

Medicine in Australia: Balancing Employment and Life
2010

General Practitioner & GP Registrar

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MABEL has been endorsed by:

Royal Australian College of General Practitioners
Australian College of Rural and Remote Medicine

Rural Doctors Association of Australia
Rural Health Workforce Australia

Australian General Practice Training

Australian General Practice Network

General Practice Registrars Australia

Royal Australasian College of Physicians

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of Ophthalmologists

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of Radiologists

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Geriatric Medicine

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Internal Medicine Society of Australia and
New Zealand

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Space is provided at the end of this survey to make additional written comments.
Please write responses in boxes provided using a dark pen. Check boxes can be ticked or crossed.

A About your current situation

- Are you currently doing any clinical medical in Australia?
 - Yes – *If yes, please go to Section B below and complete the main survey*
 - No – *Continue*
- Are you permanently retired from all types of paid work?
 - Yes – *As you are permanently retired from all types of paid work you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*
 - No – *Continue*
- Which of the following statements describe your current situation? (Tick all that apply)
 - Doing medical work in Australia that is non-clinical (e.g. medico-legal, teaching, research, committee work)
 - Maternity leave
 - Home duties/childcare
 - Enrolled as a student
 - Extended leave (e.g. sick leave, long service leave)
 - Working outside Australia in a clinical role
 - Working outside Australia in a non-clinical, but medical role
 - Working outside Australia in a non-medical role
 - Doing non-medical work in Australia. Please state job title:
- Do you intend to return to clinical medical work in Australia?
 - Yes – *Please go to Section G and complete the final two sections of the survey*
 - Unsure – *Please go to Section G and complete the final two sections of the survey*
 - No – *As you do not intend returning to clinical work in Australia you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*

B About your job satisfaction

- Please indicate how satisfied or dissatisfied you are in the various aspects of your work as a doctor.

	Very Dissatisfied	Moderately Dissatisfied	Not Sure	Moderately Satisfied	Very Satisfied	N/A
Freedom to choose your own method of working	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of variety in your work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Physical working conditions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Opportunities to use your abilities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your colleagues and fellow workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Recognition you get for good work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your hours of work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your remuneration	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of responsibility you are given	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Taking everything into consideration, how do you feel about your work?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

6. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The amount of work I delegate to other health professionals has increased in the past 12 months	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The balance between my personal and professional commitments is about right	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have a poor support network of other doctors like me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The IT systems I use are very helpful in day-to-day practice	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is difficult to take time off when I want to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My patients have unrealistic expectations about how I can help them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The majority of my patients have complex health and social problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Running my practice is stressful most of the time	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The hours I work are unpredictable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have good supervision/mentoring support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

7. Would you like to change your hours of work (including day time and after hours)?

- 1 No
- 2 Yes, I'd like to increase my hours
- 3 Yes, I'd like to decrease my hours

8. What is the likelihood that you will:

	Very Unlikely	Unlikely	Neutral	Likely	Very Likely
Leave direct patient care (primary or hospital) within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Leave medical work entirely within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Reduce your clinical workload in the next FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

9. This and the following question ask about any workplace aggression directed toward you in the last 12 months whilst you were working in medicine (i.e. any circumstance or location in which you performed your role as a medical practitioner), including:

- *Verbal or written abuse, threats, intimidation or harassment* – such as ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation;
- *Physical threats, intimidation, harassment or violence* – such as a raised hand or object, unwanted touching, damage to property and sexual or other physical assault.

For each potential source of aggression, please tick the box that most closely matches how often you experienced each type of aggression in the past 12 months.

	Frequently (once or more each week)	Often (a few times each month)	Occasionally (a few times each 6 months)	Infrequently (a few times in 12 months)	Not at all
A. Aggression from patients					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
B. Aggression from relatives or carers of patients					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C. Aggression from any workplace co-worker					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
D. Aggression from any other person external to the workplace					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

10. Please indicate whether or not the following actions to prevent or minimise aggression have been implemented in your main workplace.

	Yes	No	Unsure	
Policies, protocols and/or procedures for aggression prevention and management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Warning signs in reception and patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Alerts to high risk of aggression (e.g. on patient record)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Restricting or withdrawing access to services for aggressive persons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Incident reporting and follow-up	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Education and training (for self and other staff)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Duress alarms in consultation and treatment areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Clinician escape optimised in consultation / treatment rooms (e.g. seated closer to door than patient, two exits in rooms)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Optimised lighting, noise levels, comfort and waiting times in patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Patient / public access restrictions (e.g. advisory signs, locked doors to treatment and storage areas)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Building security systems (e.g. burglar alarms, deadlocks, window bars, surveillance cameras, security personnel)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Safety and security measures for after hours or on-call work, or home visits (e.g. security escort to external areas at night, movement register, working in pairs, satellite phones)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/> Not applicable
Other (please specify) <input type="text"/>				

C About the places where you work

11. Excluding on-call, for how many HOURS in your MOST RECENT USUAL WEEK at work did you undertake work in each of the following settings? (Include ALL of the work you do as a doctor) (If none, write 0)

	Actual hours per week
Private medical practitioner's rooms or surgery	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Community health centre or other state-run primary care organisation	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Public hospital (including psychiatric hospital)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Private hospital	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Aboriginal health service	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Government department, agency or defence forces	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Tertiary education institution	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
TOTAL HOURS WORKED	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

12. The next THREE questions relate to the place where you work. If nothing has changed since the last time you did the MABEL survey, tick box and go to question 16.

No change since I last completed the MABEL survey

13. How many GPs work in your current main practice? (Include yourself if applicable) (If none, write 0)

	Full-time	Part-time
No. of males	<input type="text"/>	<input type="text"/>
No. of females	<input type="text"/>	<input type="text"/>

14. How many other health workers or professionals are employed in your current main practice? (If none, write 0)

No. of nurses	<input type="text"/>
No. of allied health professionals	<input type="text"/>
No. of administrative staff	<input type="text"/>
No. of other staff	<input type="text"/>

24. In your most recent USUAL week at work, for around HOW MANY patients did you provide care?
 (Include face-to-face, out-of-hours and telephone consultations in ALL SETTINGS) (If none, write 0)
 Total number of patients seen in private consulting rooms.
 Total number of patients seen in hospital or other settings
25. Excluding emergencies or urgent needs, for how many days does a patient typically have to wait for an appointment with: (Please write average number of days)
 You, their preferred doctor in the practice? days
 Any doctor in the practice? days
26. How long does a NEW patient typically have to wait for an appointment in your practice?
 No. of days days
 No. of weeks weeks
 Not taking new patients at present (Tick box)
27. How long does an average consultation last? (Please write number of minutes) mins
28. Approximately what percentage of patients do you bulk bill/charge no co-payment? %
29. What is your current fee for a standard (level B) consultation? (Include Medicare rebate and patient co-payment. Please write dollar amount; write 0 if you bulk bill 100% of your patients) . . . \$
30. Do you do any on-call yourself? (Including public holidays, weekends and weekdays outside of 8am to 6pm)
¹ Yes
² No—Go to question 34
31. What are your on-call ratios for practice and hospital work?
 (For example, 5 weeknights per fortnight equals 1 in 2)
- | | Practice work | Hospital work |
|-------------------------------------|---|---|
| 1 weeknight in | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| 1 weekend in | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| Not Applicable (Tick box) | <input type="checkbox"/> | <input type="checkbox"/> |
32. In your last usual week at work, how many TIMES were you actually called out? (If none, write 0)
- | | Practice work | Hospital work |
|--------------------------------------|---|---|
| Weeknights: times per week | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| Weekend: times per weekend | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| Not Applicable (Tick box) | <input type="checkbox"/> | <input type="checkbox"/> |
33. If your on-call arrangements do not fit the above descriptions, please elaborate below:
34. Arranging a locum at short notice is usually: (Tick one box)
¹ Moderately easy
² Rather difficult
³ Very difficult
⁴ Not Applicable
35. Turning to time spent away from work: (If none, write 0)
 How many WEEKS holiday did you take in the past year? weeks
 How many WEEKS of parental or maternity leave did you take in the past year? weeks
 Approximately how many DAYS off work due to illness did you have in the past year? days
 Approximately how many DAYS off work did you have for other reasons in the past year? days

E About your finances

The following information will be used to examine the effect of financial issues on your work–life balance, and will remain strictly confidential.

36. What are your (approximate) **TOTAL PERSONAL** earnings from **ALL** of the work you do as a doctor? (If possible, base this on your last personal income tax return or payslip.) This should be your personal earnings rather than total practice earnings. Please write in **ONE COLUMN** where you have the most accurate information and can best remember.

	Annual	OR	Fortnightly
Before tax (gross earnings) \$		OR	
After tax (net earnings) \$			

37. In addition to this, did you receive any ongoing 'in kind' benefits or subsidies as part of your current job/s (e.g. car, house, school fees, salary packaging)?

¹ Yes
² No

38. What is the approximate annual total value in dollars of these benefits? (If zero, write 0)

39. What is the total level of financial debt that you currently have as a result of your medical education and training? (Give dollar amount; include HECS debt, other debt associated with training and living expenses) (If zero, write 0)

\$

Don't Know (Tick box)

40. What is the total level of financial debt that you currently have from owning your practice or premises? (If zero, write 0)

\$

Don't Know (Tick box)

Not Applicable (Tick box)

41. What is the status of your private practice for tax purposes?

¹ Sole trader
² Partnership
³ Company
⁴ Trust
⁵ Don't Know
⁶ Not Applicable

42. Do you have other sources of personal income apart from your medical work? (Profit from other business interests, dividend income, bank interest, rental income etc.)

¹ Yes
² No

43. In the last year, approximately what percentage of your total gross earnings did you receive from each of the following sources? (Please enter percentage figure where applicable)

Payments from patients for services covered by Medicare (include Medicare rebate and patient co-payment)		%
Payments from patients for services not covered by Medicare (e.g. insurance, certificates, private patients)		%
Government incentive schemes and grants (e.g. rural incentives)		%
Hospital work (salary and other payments)		%
Other sources (including non-medical/business; specify source and %) <div style="border: 1px solid black; width: 150px; height: 20px; display: inline-block;"></div>		%
TOTAL	100	%

44. Do you (or your employer) regularly contribute to a superannuation scheme?

- ¹ Yes
- ² No

45. Please indicate the degree to which you agree with the following statement: "Given my current financial situation and prospects, I believe I will have enough to live on when I retire". (Tick one box)

- ¹ Strongly Disagree
- ² Disagree
- ³ Neutral
- ⁴ Agree
- ⁵ Strongly Agree

46. How much (in dollars) did you pay for professional medical liability, or malpractice, insurance premiums in the last year?

(If this was provided by someone else on your behalf, write 0)

47. What is your total gross and net HOUSEHOLD income? (Include your and your partner's earnings, income from other business interests, dividends, interest etc.) The figures below should be equal to or greater than your personal earnings provided in question 36. Please write in ONE COLUMN ONLY, where you have the most accurate information or can best remember.

	Annual	OR	Fortnightly
Before tax (gross household income) \$			
After tax (net household income) \$			

F

 About your geographic location

48. In how many locations do you practise?

49. Where is your main place of work?
 Unchanged since I last completed the MABEL Survey (Go to question 52)
 Town/Suburb
 Postcode

50. Where do you live?
 Unchanged since I last completed the MABEL survey
 Town/Suburb
 Postcode

51. The opportunities for social interaction for you and your family in the geographic location of your main job are: (Tick one box)

- ¹ Very limited
- ² Average
- ³ Very good

52. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I don't have many friends or family members in my current work location	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶
It is easy to pursue my hobbies and leisure interests in my current work location	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶
My partner does not have many friends or family members in this work location	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶
There are good employment opportunities for my partner in this work location	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶
The choice of schools for our children is adequate in this location	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶

53. Are you subject to restrictions on where you practise?

- ¹ Yes—I am required to work in an Area of Need
- ² Yes—I am required to work in a District of Workforce Shortage
- ³ No—Go to question 55

54. Please indicate the reason/s for these restrictions.

- I hold a Permanent Resident Visa
- I hold a Temporary Resident Visa
- I am undertaking a return of service period for a Medical Rural Bonded Scholarship or Bonded Medical Place
- I am undertaking a compulsory rural placement as part of my training
- Other

G About your family circumstances

55. Are you currently living with a partner or spouse?

- ¹ Yes
- ² No

56. What is the employment status of your partner/spouse?

- ¹ Not in the labour force (e.g. caring for dependents, studying)
- ² Currently seeking work
- ³ Full-time employment
- ⁴ Part-time employment
- ⁵ Not Applicable

57. Is your partner/spouse also a medical doctor?

- ¹ Yes
- ² No
- ³ Not Applicable

58. For how many years did your partner/spouse live in a rural area up until the age he/she left secondary school? (If none, write 0)

Don't know (Tick box)

Not Applicable (Tick box)

59. Please indicate the main rural area where your partner/spouse lived up until school leaving age.

Town

State

Don't know (Tick box)

Not Applicable (Tick box)

60. How many dependent children do you have?

--	--

61. What is the age in years of each dependent child?

Not Applicable (Tick box)

Child 1

--	--

Child 2

--	--

Child 3

--	--

Child 4

--	--

Child 5

--	--

Child 6

--	--

62. Which of the following forms of childcare are you using for your children of pre-school age? (Please tick all that apply)

- Relatives or friends
- Nannies
- Childcare at work (i.e. provided by an employer)
- Other day care (childcare centre, family day care, kindergarten etc.)
- Not Applicable

63. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am restricted in my employment and/or the time and hours I work due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is restricted in his/her employment and/or the time and hours worked due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is overqualified for his/her current job due to the limited availability of suitable jobs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

H About you

64. Please list any GP and other medical qualifications you have obtained in Australia since the last time you completed the MABEL Survey (e.g. FRACGP, FRACP, FACRRM, AMC Certificate examination, diploma).

Not Applicable (Tick box)

1

2

3

4

5

65. Do you have medical qualifications from overseas which are NOT recognised in Australia?

- 1 Yes
- 2 No
- 3 Unsure

66. If you are a new GP Registrar this year:

In what year do you expect to complete the program and become a Fellow?

Not Applicable (Tick box)

67. What is your residency status? (Tick one box)

- 1 Unchanged since I last completed the MABEL survey
- 2 Australian citizen
- 3 Permanent resident
- 4 Temporary resident

68. What type of medical registration do you have?

- 1 Unchanged since I last completed the MABEL survey
- 2 Full (unconditional) medical registration
- 3 Conditional medical registration
- 4 Other (please specify)

