Ahpra & National Boards

Attend program of treatment

Practitioner acknowledgement

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
- If available on your computer or device, you may be able to complete and sign this form electronically. Otherwise, print, complete, sign and return a scan or clear photo of the form.

Collection of personal information and health information

We are committed to protecting your personal information. The ways in which we may collect use and disclose your information are set out in our *Privacy policy*.

Further information regarding *Ahpra's privacy, Freedom of information and information publication scheme* is available on Ahpra's website.

Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Practitioner's declaration

By checking the boxes below and signing this form, I acknowledge and confirm:

☐ I have read and understood the *Ahpra Protocol: Attend a program of treatment*.

Date

D D / M M / Y Y Y Y

Signature

SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Attend program of treatment

Nomination of practice location

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Practice location details

Place of practice 1

Name of practice

Street address

Name of senior person (first and last)

Position of senior person

Email of senior person

Phone number of senior person

Place of practice 2

Name of practice

Street address

Name of senior person (first and last)

Position of senior person

Email of senior person

Phone number of senior person

Place of practice 3

Name of practice

Street address

Name of senior person (first and last)

Position of senior person

Email of senior person

Phone number of senior person

Practitioner's declaration

By checking the boxes below and signing this form, I acknowledge and confirm:

- ☒ that upon publication of approved practice locations, I must only practice at the approved practice locations as published.
- ☒ I must only practice in accordance with the practice limitations published on the National public register.
- ☒ I do not have any perceived or actual conflict of interest with my nominated senior person at each practice location.
- ☒ I give consent to Ahpra sharing information with the nominated senior person and requesting information from the senior person.
- ☒ I understand and agree that Ahpra may use, collect and disclose my information in accordance with the Privacy Policy.

Date

D D / M M / Y Y Y Y

Signature

SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Attend program of treatment

Senior person acknowledgement

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
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Collection of personal information and health information

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Senior person details

Name (first and last)

Place of practice

Position

Registration number (if registered)

Email

Telephone

Senior person's declaration

By checking the following boxes and signing this form, I acknowledge and confirm:

☐ I do not have any perceived or actual conflict of interest in undertaking the role of senior person

☐ I understand the practitioner must not practise unless a practice location has been published on the National public register, and that the practitioner must only practice at published practice locations.

☐ I have received a copy of the *Ahpra Protocol: Attend program of treatment*, and copy of the restrictions on the practitioner's registration, and I am aware of the reasons for the restrictions imposed.

☐ I am aware that, for the purposes of monitoring the practitioner's compliance, Ahpra may request information from me including details of the proposed return to work arrangements.

☐ I have been provided the contact details of the Ahpra case officer or team.

☐ I understand and agree that Ahpra may use, collect and disclose my information in accordance with the Privacy Policy.

Date D D / M M / Y Y Y Y

Signature SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Attend program of treatment

Treating practitioner nomination

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
- If available on your computer or device, you may be able to complete and sign this form electronically. Otherwise, print, complete, sign and return a scan or clear photo of the form.

Collection of personal information and health information

We are committed to protecting your personal information. The ways in which we may collect use and disclose your information are set out in our *Privacy policy*.

Further information regarding *Ahpra's privacy, Freedom of information and information publication scheme* is available on Ahpra's website.

Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Treating practitioner details

Name (first and last)

Profession

Registration number

Email

Telephone

Practitioner's declaration

By checking the following boxes and signing this form, I acknowledge and confirm:

- ☐ I do not have any actual or perceived conflict of interest with the nominated treating practitioner.
- ☐ the treating practitioner may provide information about my health condition and treatment to Ahpra.
- ☐ I consent to Ahpra sharing information with the treating practitioner and requesting information from the treating practitioner.
- ☐ I have provided the treating practitioner with a copy of the Protocol and the restrictions on my registration.
- ☐ I am aware that Ahpra may provide a copy of the restrictions to the treating practitioner if required.
- ☐ I have provided the treating practitioner with the contact details of my Ahpra case officer or team.
- ☐ I understand and agree that Ahpra may use, collect and disclose my information in accordance with the Privacy Policy.

Date DD / MM / YYYY

Signature SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Attend program of treatment

Treating practitioner acknowledgement

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
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Collection of personal information and health information

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Treating practitioner details

Name (first and last)

Profession

Registration number

Email

Telephone

Treating practitioner's declaration

By checking the following boxes and signing this form, I acknowledge and confirm:

- ☐ I do not have any actual or perceived conflict of interest in undertaking the role of treating practitioner.
- ☐ I have received a copy of the *Ahpra Protocol: Attend a program of treatment*.
- ☐ I have been provided with a full text copy of the practitioner's restrictions and I am aware of the reasons for the restrictions imposed.
- ☐ I am aware that, for the purposes of monitoring the practitioner's compliance and/or health, Ahpra may request reports from me, and I agree to provide the reports at the required frequency.
- ☐ I am aware that I must contact Ahpra if there is a change to the practitioner's health that may impact on safe practise.
- ☐ I have been provided the contact details of the Ahpra case officer or team.
- ☐ I understand and agree that Ahpra may use, collect and disclose my information in accordance with the Privacy Policy.

Date DD / MM / YYYY

Signature SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495