Limitations on practice
Practitioner acknowledgement

Practitioner's Details
Monitoring & Compliance number
Name (Last, First)

Practitioner’s Declaration
By signing this form I acknowledge and confirm that:

1. For the purposes of monitoring my compliance with the condition limiting my practice, AHPRA may contact the senior person at each of my places of practice and:
   a. access rosters, timesheets or similar information, and
   b. obtain reports. These reports may be obtained or provided:
      i. on the timeframe indicated in the conditions on my registration limiting my practice
      ii. when a senior person holds a concern or becomes aware of a concern about my competence, conduct or fitness to practice the profession, and
      iii. at other times as required by AHPRA or the Board.

2. AHPRA may have contact with and access information, where relevant, from Medicare, private health insurers and/or private practice billing data.

3. AHPRA must be notified within two business days of any incident where, due to a medical emergency, I am unable to comply with the condition limiting my practice. I understand that:
   a. The circumstances must be such that compliance with the condition would directly affect my ability to provide care that would have a direct benefit to a patient in a medical emergency.
   b. A medical emergency is defined as an event where it is not possible or reasonable to have a patient with a serious or life threatening condition seen by another practitioner or transferred to the nearest hospital.
   c. AHPRA will treat any failure to notify non-compliance in the circumstances of a medical emergency within the requisite timeframe as a breach of the condition and will report such breach to the Board, who may take further action in relation to a breach of conditions.

Signature
Date

Return form to
Case officer
Email
Post

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## Practitioner's Details

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<thead>
<tr>
<th>Monitoring &amp; Compliance number</th>
<th>Name (Last, First)</th>
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## Senior Person Details

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
<th>Registration number (if registered)</th>
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<tbody>
<tr>
<td>Position title</td>
<td></td>
</tr>
<tr>
<td>Place of Practice</td>
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<tr>
<td>Postal address</td>
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<td>Email</td>
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</tr>
<tr>
<td>Contact numbers</td>
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## Senior Person Declaration

By signing this form, I acknowledge and confirm:

1. I have seen a copy of the conditions on the Practitioner’s registration as demonstrated by my signature on the attached schedule of conditions.

2. I am aware that, for the purposes of monitoring the Practitioner’s compliance with the conditions limiting their practice, AHPRA may access rosters, timesheets or similar information.

3. I am aware that AHPRA may request reports from me. These reports may be sought or provided:
   a. on the timeframe indicated in the conditions on the Practitioner’s registration limiting their practice
   b. when I hold a concern or become aware of a concern about the Practitioner’s competence, conduct or fitness to practise the profession, and
   c. at other times as required by AHPRA or the Board.

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## Return form to

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