Ahpra & National Boards

Restrictions on access to medication

Practitioner acknowledgement

Practitioner's details

Name

Monitoring & compliance number

Practitioner's declaration

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

☐ 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 to obtain reports and seek information about how the conditions on my registration, which restrict access to medications, are accommodated in my workplace. These reports will be obtained and/or provided as follows:

a. On the timeframe indicated in the conditions on my registration restricting access to medication

b. at other times as required by Ahpra or the Board, and

c. when a senior person holds a concern or becomes aware of a concern about my competence, conduct or fitness to practice the profession.

☐ Ahpra may have contact with and access information from Medicare and/or local drugs and poisons regulatory authorities in relevant states and territories.

☐ 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 restricting access to medication. 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

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

Sydney NSW 2001	Canberra ACT 2601	Melbourne VIC 3001
Brisbane QLD 4001	Adelaide SA 5001	Perth WA 6001
Hobart TAS 7001	Darwin NT 0801	

IMPORTANT: please quote your monitoring and compliance number when submitting your forms to Ahpra - <<[compliance_number]>>

Ahpra & National Boards

Restrictions on access to medication

Senior person acknowledgement

Practitioner's details

Name

Monitoring & compliance number

Senior person's details

Name (Last, First)

Registration number

Position title

Place of practice

Postal address

Contact number

Email

Senior person's declaration

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

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

☐ I am aware that, for the purposes of monitoring the Practitioner's compliance with the conditions on their registration, Ahpra may request reports from me to provide information about how the conditions, restricting access to medication, are accommodated in the Practitioner's workplace. These reports may be sought or provided:

a. on the timeframe indicated in the conditions on the Practitioner's registration restricting access to medication

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.

Signature

Date

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

Sydney NSW 2001	Canberra ACT 2601	Melbourne VIC 3001
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IMPORTANT: please quote your monitoring and compliance number when submitting your forms to Ahpra - <<[compliance_number]>>