Restrictions on access to medication
Practitioner acknowledgement

Practitioner’s Details

Monitoring & Compliance number
Name (Last, First)

Practitioner’s Declaration

By signing this form, I acknowledge and confirm:

1. AHPRA may contact the senior person at every place I practise 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 condition on my registration restricting access to medications
   b. at other times as required by AHPRA or the Board, and
   c. when the senior person holds a concern or becomes aware of a concern about my competence, conduct or fitness to practise.

2. AHPRA may, where relevant, have contact with and access information from Medicare, and/or local drugs and poisons regulatory authorities in relevant states and territories.

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 restricting access to medications. 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
### 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>
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<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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<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, in order to monitor the Practitioner’s compliance with the condition on their registration restricting access to medication, AHPRA may request reports from me in accordance with the timeframe outlined in the conditions on the Practitioner’s registration. These reports:

   a. are to provide information about how the conditions, restricting access to medication, are accommodated in the Practitioner’s workplace, and
   
   b. I may provide additional reports whenever I hold a concern or become aware of a concern about the Practitioner’s competence, conduct or fitness to practise the profession.

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<th>Signature</th>
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### Return form to

| Case officer | Email | Post |

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