Ahpra & National Boards

Supervised access to medication(s)

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

sdff

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

Place of practice 2

Name of practice

Street address

Name of senior person (first and last)

Position of senior person

Email 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

Practitioner's declaration

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

- ☒ I have read and understood the restriction and *Ahpra Protocol: Supervised access to medication* and the *Ahpra Protocol: Audit*
- ☒ The details I have provided are true and accurate and represent all locations at which I was practising at the time of the imposition of the restrictions.
- ☒ I confirm that I do not have any actual or perceived conflict of interest with the senior person at each practice location.
- ☒ 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

Supervised access to medication(s)

Nomination of practice location

Completing this form

- Print clearly in BLOCK LETTERS
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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Place of practice 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

Place of practice 2

Name of practice

Street address

Name of senior person (first and last)

Position of senior person

Email 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

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 restrictions 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 must not access the substances defined in my restrictions if I have not nominated an observer for approval.
- ☒ 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

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You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Supervised access to medication(s)

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

Email

Telephone

Senior person 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: Supervised access to medication a*nd if required, the *Ahpra Protocol: Complete audit.*.

☐ I have received a 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 reports from me including rosters, timesheets, appointment diaries or billing or similar information and I agree to provide the reports at the required frequency.

☐ 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

Supervised access to medication(s)

Nomination of observer

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

Nomination details

Nominee 1

Name (first and last)

Registration number (if registered)

Place of practice

Postal address

Email

Telephone

Nominee 2

Name (first and last)

Registration number (if registered)

Place of practice

Postal address

Email

Telephone

Nominee 3

Name (first and last)

Registration number (if registered)

Place of practice

Postal address

Email

Telephone

Practitioner's declaration

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

- ☒ that this information is accurate and represents all staff at each approved practice location that are responsible for observing my access to medications.
- ☒ I confirm that I do not have any perceived or actual conflict of interest with my nominated observer(s)
- ☒ 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

Supervised access to medication(s)

Observer 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

Nominee details

Name (first and last)

Registration number (if registered)

Place of practice

Postal address

Email

Telephone

Observer 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 observer.
- ☐ I am willing to act in the capacity of observer for the purposes of the restrictions.
- ☐ I have/have not discussed with my employer any concerns relating to the role of observer for the purposes of these restrictions.
- ☐ I have received a copy of the *Ahpra Protocol: Supervised access to medications*.
- ☐ I have received a copy of the restrictions on the practitioner's registration, and I am aware of the reasons for the restrictions imposed.
- ☐ I am aware that Ahpra may contact me to discuss the management of the practitioner's restriction in the workplace.
- ☐ I have been provided the contact details of the Ahpra case officer or team. and I am aware that I can contact the case officer at any time if I have any concerns.
- ☐ 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