Ahpra & National Boards

Prohibition on patient group: sex and gender

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

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

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: Prohibition on patient type: sex and gender*.
- ☒ 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 declare that I have ceased practising from the declared location(s) above.
- ☒ 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

Prohibition on patient group: sex and gender

Nomination of practice location and senior person

Completing this form

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Practice location and senior person 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

Name of registered health practitioners at practice location

Email/telephone of registered health practitioners at practice location

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

Name of registered health practitioners at practice location

Email/telephone of registered health practitioners at practice location

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

Name of registered health practitioners at practice location

Email/telephone of registered health practitioners at practice location

Senior person's declaration

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

- ☒ I must only practice at approved practice locations that are published to the National public register.
- ☒ the nominated practice locations meet the requirements to support my compliance with the *Ahpra Protocol: Prohibition on patient type: sex and gender*.
- ☒ I must not have contact with any patient of the assigned sex and/or gender detailed in the restrictions on my registration (prohibited patients).
- ☒ I am aware that the definition of patient includes any person accompanying the individual awaiting, requiring, or receiving the professional services of the practitioner and includes any spouse, partner, parent, dependent, family member or guardian/carer.
- ☒ I do not have any actual or perceived conflict of interest with the senior person at each practice location
- ☒ I consent to Ahpra sharing information with the nominated senior person and requesting information from 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

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You may contact Ahpra on 1300 419 495

Ahpra & National Boards

Prohibition on patient group: sex and gender

Nomination of practice staff

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 staff nomination details

Nominee 1

Name (first and last)

Registration number (if registered)

Place of practice

Position

Contact telephone number

Contact email address

Nominee 2

Name (first and last)

Registration number (if registered)

Place of practice

Position

Contact telephone number

Contact email address

Nominee 3

Name (first and last)

Registration number (if registered)

Place of practice

Position

Contact telephone number

Contact email address

Practitioner's declaration

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

- ☒ this information is true and accurate and represents all staff (including the senior person if they manage patients) at each nominated practice location that are responsible for the management of patients.
- ☒ I do not have any actual or perceived conflict of interest with the nominated practice staff at each nominated practice location.
- ☒ I give consent to Ahpra sharing information with the nominated practice staff and requesting information from the practice staff
- ☒ 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

Prohibition on patient group: sex and gender

Practice staff 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

Practice staff details

Name (first and last)

Position

Registration number

Place of practice

Postal address

Contact email address

Contact telephone number

Practice staff declaration

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

- ☒ I do not have any actual or perceived conflict of interest in undertaking the role of practice staff.
- ☒ I have been provided with a copy of the practitioner's restrictions, and I am aware of the reasons for the restrictions imposed.
- ☒ I have received a copy of the *Ahpra Protocol: Prohibition on patient type: sex and gender*.
- ☒ I am aware that all patients who meet the definition of prohibited patient must not be booked for an appointment or be permitted to have contact with the practitioner.
- ☒ I am aware that the definition of patient includes any person accompanying the individual awaiting, requiring, or receiving the professional services of the practitioner and includes any spouse, partner, parent, dependent, family member or guardian/carer.
- ☒ I have been provided the contact details of the Ahpra case officer or team.
- ☒ I am aware that Ahpra may contact me to discuss the management of the practitioner's restriction in the workplace.
- ☒ I am aware that I may contact the Ahpra at any time if I have concerns relating to the role of practice staff for the purposes of these restrictions.
- ☒ I am aware I can withdraw from the role of practice staff at any time by notifying Ahpra in writing.
- ☒ I would/would not like contact from Ahpra to discuss the role of practice staff for the purposes of the practitioner's restrictions.
- ☒ I have provided a copy of my photo identification with this form.
- ☒ 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

Prohibition on patient group: sex and gender

Senior person acknowledgement

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

Senior person details

Name (first and last)

Place of practice

Position

Registration number (if registered)

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: Prohibition on patient type: sex and gender*.
- ☐ I have been provided with a copy of the practitioner's restrictions, and I am aware of the reasons for the restrictions imposed.
- ☐ I understand the practitioner must not have contact with patients who meet the definition of prohibited patient, and these patients must not be permitted to have contact with the practitioner.
- ☐ I am aware that the definition of patient includes any person accompanying the individual awaiting, requiring, or receiving the professional services of the practitioner and includes any spouse, partner, parent, dependent, family member or guardian/carer.
- ☐ I have been provided the contact details of the Ahpra case officer or team.
- ☐ I am aware that Ahpra may contact me to discuss the management of the practitioner's restriction in the workplace.
- ☐ I am aware that I may contact the Ahpra at any time if I have concerns relating to the role of senior person for the purposes of these restrictions.
- ☐ I am aware that, for the purposes of monitoring the practitioner's compliance, I must provide to Ahpra at their request information including reports rosters, timesheets, appointment diaries, billing information and patient records or similar information, and I agree to provide the reports at the required frequency.
- ☐ 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

Prohibition on patient group: sex and gender

Other registered practitioner acknowledgement

Completing this form

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Other registered health practitioners (RHP) details

Name (first and last)

Any alternative names known by

Place of practice

Position

Registration number

Email

Telephone

Other RHP 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 practitioner.
- ☐ I have been provided with a copy of the practitioner's restrictions, and I am aware of the reasons for the restrictions imposed.
- ☐ I have received a copy of the *Ahpra Protocol: Prohibition on patient type: sex and gender*.
- ☐ I understand the practitioner must not have contact with patients who meet the definition of prohibited patient, and these patients must not be permitted to have contact with the practitioner.
- ☐ I am aware that the definition of patient includes any person accompanying the individual awaiting, requiring, or receiving the professional services of the practitioner and includes any spouse, partner, parent, dependent, family member or guardian/carer.
- ☐ I have been provided the contact details of the Ahpra case officer or team.
- ☐ I am aware of my mandatory reporting obligations under section 141 of the National Law.
- ☐ I am aware that I may contact the Ahpra at any time if I have concerns relating to the practitioner.
- ☐ 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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