DFLP-00

Declaration form - application

Type: Limited and provisional registration

Health Practitioner Regulation National Law (the National Law)

This form is for supervisors, employers, sponsors and education providers of applicants applying for limited or provisional registration with Board approved arrangements.

The applicant must complete the personal details and requirements. The declarations must be completed by the supervisor, employer, sponsor and/or education provider of the applicant. This declaration form must be included as part of the applicant's application.

For IMGs, the principal supervisor's declaration is found in *Supervised practice plan and supervisor's agreement for international medical graduates – SPPA-30* and must be submitted with your application for registration.

Symbols in this form

Additional information
Provides specific information about a question or section of the form.

Attention
Highlights important information about the form.

Attach document(s) to this form
Processing cannot occur until all required documents are received.

Signature required
Requests appropriate parties to sign the form where indicated.

Completing this form

- Read and **complete all questions**.
- Ensure that **all pages** and required **attachments** are returned to Ahpra.
- Use a **black** or **blue** pen only.
- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes:
- **DO NOT send original documents unless specified.**

Do not use staples or glue, or affix sticky notes to your application. Please ensure all supporting documents are on A4 size paper.

PART A – To be completed by the applicant

SECTION A: Personal details

1. What is your name?

Title MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER SPECIFY

Family name

First given name

Middle name(s)

2. What is your date of birth?

Date of birth

DD / MM / YYYY

SECTION B: Details of the position

3. What is the title of the position for which registration is being sought?

Title of the position

4. What are the names and addresses of all sites of practice for which registration is being sought?

Provide the name and address of each site for which limited registration is required to undertake clinical practice.

Board approval does not provide access to Medicare provider number.

Full name of hospital/practice/clinic

Phone number

Site/building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT)

Postcode*

Full name of hospital/practice/clinic

Phone number

Site/building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT)

Postcode*

Attach a separate sheet of the names and addresses of additional sites that do not fit in the space provided.

PART B – To be completed by the principal/primary supervisor

SECTION C: Principal supervisor's undertaking

5. What are your contact details?

Title MR MRS MISS MS DR OTHER SPECIFY

Family (legal) name of supervisor

First given name

Registration number

Position

Work address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT)

Postcode*

Business hours

Mobile

Email

6. If a supervised practice plan is required for this applicant, it must be attached to this document upon submission.

Attach the supervised practice plan. Visit **www.ahpra.gov.au** to download the appropriate supervised practice plan associated with your Board.

Undertaking

I undertake to be the applicant's principal/primary supervisor and to provide a level of supervision required by the Board and as otherwise determined from time to time by the Board.

I further undertake to:

- ensure that the applicant is practising safely and is not placing the public at risk.
- ensure the applicant only works within the scope and terms of their registration.
- observe the applicant's work, conduct other supervision activities as required and identify and address any problems.
- notify the Board immediately if I have concerns about the applicant's clinical performance, health or failure to comply with conditions or undertakings.
- obtain approval of the Board for any proposed changes to work arrangements before they are implemented.
- inform the Board if I am no longer able to undertake the role of the applicant's supervisor.
- ensure that, in delegating day to day supervision to other practitioners, they have the relevant registration in accordance with the National Law, and
- provide supervision and work performance reports as required by the Board, in a form approved by the Board.

I declare that the:

- information provided in this document (including supervision and training details) is true and correct.
- applicant named in this document will be supervised at all times while undertaking practice in their relevant profession in accordance with their registration type and the Boards guidelines on supervision.

Name of applicant

Name of principal/primary supervisor

Date

D D / M M / Y Y Y Y

Signature of principal/primary supervisor

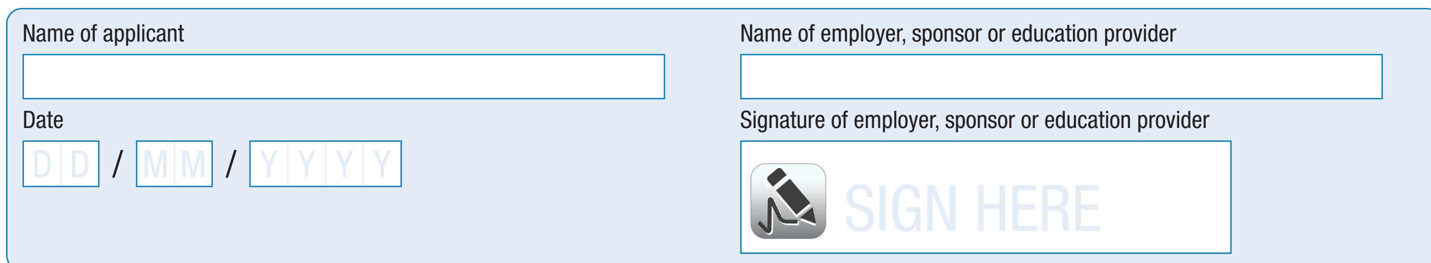
SIGN HERE

PART C – To be completed by the employer/sponsor/education provider

SECTION D: Declaration

Employer/sponsor/education provider contact must be the same as per this declaration form.

I declare that all the information provided in this form is true and correct.



Name of applicant

Name of employer, sponsor or education provider

Date

D D / M M / Y Y Y Y

Signature of employer, sponsor or education provider

SIGN HERE

PART D – To be completed by the applicant

SECTION E: Checklist

Have the following items been attached or arranged, if required?

Additional documentation		**Attached**
Question 4	A separate sheet of the names and addresses of additional sites	☐
Question 6	A supervised practice plan	☐

Do not email this form.

Please submit this completed form and supporting evidence using the Online Upload Service at **www.ahpra.gov.au/registration/online-upload** or practitioner portal. You may contact Ahpra on 1300 419 495