



Supervised practice framework: 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

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 and signing this form, I acknowledge and confirm:**

- ☐ I do not have any actual or perceived conflict of interest with the senior person at each practice location.
- ☐ I have read and understood the restrictions on my registration and the [Supervised practice framework](#).
- ☐ I have provided true and accurate details that represent all locations at which I was practising at the time of the imposition of the restrictions.
- ☐ I am aware that Ahpra may provide a copy of the restrictions on my registration, including restrictions not published on the public register to my approved supervisor and senior person.
- ☐ I am aware that for the purposes of monitoring my compliance with the restrictions on my registration requiring supervised practice, Ahpra may obtain information and/or reports from:
 - ☐ relevant authorities (such as, but not limited to Medicare and/or private health insurers)
 - ☐ the senior person at each of my practice locations, and
 - ☐ the approved supervisor(s).
- ☐ Any hours completed in accordance with my supervised practice arrangement must not be used to satisfy CPD requirements.
- ☐ I am aware that Ahpra may audit to ensure the supervision is not used as contribution to any current or future CPD period.
- ☐ I understand and agree that Ahpra may use, collect and disclose my information in accordance with the [Privacy Policy](#).

Date

 / /

Signature



SIGN HERE

When completed, return this form to compliance@ahpra.gov.au

You may contact Ahpra on 1300 419 495



Supervised practice framework: Nomination of supervisor

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Nomination details

Supervisor name (first and last)

Profession

Registration number

Email

Telephone

Practitioner's declaration

By signing this form, I acknowledge and confirm:

- ☒ I do not have any actual or perceived conflict of interest with the nominated supervisor.
- ☒ I have provided the nominee with a copy of the restrictions on my registration.
- ☒ I am aware that Ahpra may provide a copy of the restrictions to the nominee if required.
- ☒ I have provided the nominee with the contact details of my 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

 / /

Signature



SIGN HERE

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Supervised practice framework: Supervisor nominee acknowledgement

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Nominee details

Supervisor name (first and last)

Profession

Registration number

Email

Telephone

Nominee acknowledgement

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

- ☒ I do not have a conflict of interest in undertaking the role of supervisor for the practitioner.
- ☒ I have accessed, read and understood the information available on the Ahpra website about [supervised practice](#) and the [Supervised practice framework](#), including my obligations as a supervisor as they apply to the practitioner's supervision arrangement.
- ☒ I have been provided with a copy of the restrictions on the practitioner's registration, including any restrictions not published on the national register due to privacy obligations, and I am aware of the reasons for the restrictions imposed.
- ☒ I agree to provide reports to Ahpra or the Board as follows:
 - ☒ in accordance with the timeframe outlined in the monitoring plan
 - ☒ whenever I have a concern or become aware of a concern regarding the practitioner's conduct or professional performance
 - ☒ otherwise in accordance with the reporting requirements of the Supervised practice framework, and
 - ☒ on request by Ahpra or the Board.
- ☒ 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

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Signature



SIGN HERE

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You may contact Ahpra on 1300 419 495



Supervised practice framework: Senior person acknowledgement

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Practitioner details

Practitioner legal name (first and last)

Compliance or registration number

Senior person details

Name (first and last)

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 actual or perceived conflict of interest in undertaking the role of senior person for the practitioner.
- ☒ I understand the practitioner must not practise unless under the supervision of an approved supervisor.
- ☒ I have been provided with a full copy of the practitioner's restrictions, including any that are not published on the National register due to privacy obligations and I am aware of the reasons for the restrictions imposed.
- ☒ I have accessed, read and understood the information available on the Ahpra website about [supervised practice](#) and the [Supervised practice framework](#).
- ☒ I am aware that, for the purposes of monitoring the practitioner's compliance with their restrictions requiring supervised practice, Ahpra may request reports from me, 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

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Signature



SIGN HERE

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