

**Form Number SE-9**

**Complete re-entry to practice program**

 **Nursing and Midwifery Board of Australia**

Practitioner Details

By signing this form I acknowledge and confirm:

1. I have read and understood the definition of ‘practice’ as it relates to the conditions on my registration.
2. I am aware that I may only practise to undertake the clinical training required for the approved re-entry to practice program.

Practitioner’s declaration

Name

(Last, First)

Monitoring & Compliance number

Signature

Date

Return form to

Post

Email

Case officer