

Restricted practice:

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
Practitioner's acknowledgement	
By signing this form, I acknowledge and confirm I have read at if required, the <i>Ahpra Protocol: Audit</i> .	nd understood the restrictions and the Ahpra Protocol: Practice limitations and
Date DD / MM / YYYYY	Signature SIGN HERE
When completed, retu	ırn this form to compliance@ahpra.gov.au

Effective from: 16 September 2024



Restricted practice:

Nomination of practice location

Completing this form

- Print clearly in BLOCK LETTERS
- Place X in all applicable boxes: x
- 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 <u>Ahpra's privacy</u>, <u>Freedom of information and information publication scheme</u> is available on Ahpra's website.

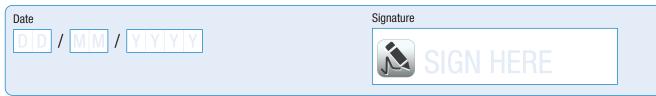
Practitioner details	
Practitioner legal name (first and last)	Compliance or registration number
Place of practice details	
Place of practice 1	
Name of practice	
Street address	
Name of senior person (first and last)	Position of senior person
Email of senior person	
Place of practice 2	
Name of practice	
Street address	
Name of senior person (first and last)	Position of senior person
position and lasty	
Email of senior person	

Effective from: 16 September 2024 Page 1 of 2

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 those approved practice locations
- I must only practice in accordance with the practice limitations 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 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.



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

You may contact Ahpra on 1300 419 495



Restricted practice:

Senior person 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 <u>Ahpra's privacy, Freedom of information and information publication scheme</u> is available on Ahpra's website.

Practitioner details		
Practitioner legal name (first and last)	Compliance or registration n	umber
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		
I do not have any perceived or actual conflict of interest in undertaking the	·	
I understand the practitioner must not practise unless a practice location has only practice at published practice locations.	is been published on the National public register, and that the	practitioner must
I have received a copy of the Ahpra Protocol: Practice limitations.		
I have received a copy of the restrictions on the practitioner's registration,	nd I am aware of the reasons for the restrictions imposed.	
I am aware that, for the purposes of monitoring the practitioner's compliar diaries or billing or similar information and I agree to provide the reports a		sheets, appointment
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 inform	ation in accordance with the <u>Privacy Policy</u> .	
Date	Signature	
DD/MM/YYYY	SIGN HERE	

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

You may contact Ahpra on 1300 419 495