Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

AHPRA

Australian Health Practitioner Regulation Agency

Supervised practice
Practitioner acknowledgement

HP9

Practitioner's Details

Monitoring & Compliance number		Name (Last, First)	

Practitioner's Declaration

By signing this form I acknowledge and confirm:

1. That for the purposes of monitoring my compliance with the conditions on my registration requiring supervised practice AHPRA may obtain information and/or reports from:
   a. relevant authorities (such as, but not limited to Medicare and/or private health insurers)
   b. the senior person at each of my places of practice, and
   c. the approved supervisor(s).
2. AHPRA must be notified within two business days of any incident where, due to a medical emergency, I am unable to comply with the condition requiring my practice to be supervised. I understand that:
   a. The circumstances must be such that compliance with the condition would directly affect my ability to provide care that would have a direct benefit to a patient in a medical emergency.
   b. A medical emergency is defined as an event where it is not possible or reasonable to have a patient with a serious or life threatening condition seen by another practitioner or transferred to the nearest hospital.
   c. AHPRA will treat any failure to notify non-compliance in the circumstances of a medical emergency within the requisite timeframe as a breach of the condition and will report such breach to the Board, who may take further action in relation to a breach of conditions.

Signature		Date	

Return form to

Case officer		Email		Post	

AHPRA

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Australian Health Practitioner Regulation Agency

Supervised practice
Senior person acknowledgement

HPS9

Practitioner's Details

Monitoring & Compliance number		Name (Last, First)	

Senior Person Details

Name (Last, First)		Registration number (if registered)	
Position title			
Place of Practice			
Postal address			
Email			
Contact numbers			

Senior Person Declaration

By signing this form I acknowledge and confirm that:

1. I have seen a copy of the conditions on the Practitioner's registration, as demonstrated by my signature on the attached schedule of conditions.
2. I am aware that, for the purposes of monitoring the Practitioner's compliance with the condition on their registration requiring supervised practice, AHPRA may request reports from me.

Signature		Date	

Return form to

Case officer		Email		Post	