Ahpra & National Boards

Common restrictions

Practitioner declaration

Practitioner's details

Name

Monitoring & compliance number

Place of practice and Senior personal details

Place of practice 1

Address

Name of senior person (If you are self-employed at this location, write "Self-employed")

Position title of senior person

Phone number of senior person

Email of senior person

Place of practice 2

Address

Name of senior person (If you are self-employed at this location, write "Self-employed")

Position title of senior person

Phone number of senior person

Email of senior person

Place of practice 3

Address

Name of senior person (If you are self-employed at this location, write "Self-employed")

Position title of senior person

Phone number of senior person

Email of senior person

Place of practice 4

Address

Name of senior person (If you are self-employed at this location, write "Self-employed")

Position title of senior person

Phone number of senior person

Email of senior person

Practitioner's declaration

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

- ☐ The details I have provided above are true and accurate and represent all locations at which I currently practice.
- ☐ I am aware that, unless expressly provided for within a condition, all costs associated with compliance with all of the conditions on my registration are my own expense.
- ☐ I am aware that should I change my place of practice, I must provide Ahpra details of each subsequent place within seven days of commencing practice.

Additionally, where I am not self-employed at a place of practice, I acknowledge and confirm:

- ☐ I have provided the senior person at each place of practice with a copy of the conditions on my registration.
- ☐ Ahpra will contact the senior person and provide them with a copy of the conditions on my registration or confirm they have received a copy of the conditions.
- ☐ I am aware that, should I change my place of practice, I must provide a copy of the conditions on my registration to the senior person at each subsequent place of practice.
- ☐ I am aware that, within seven days of notice of any alteration to the conditions on my registration, I must again provide the senior person at each and every place of practice with details of the alteration to these conditions.

Signature

Date

When completed, return this form to:

Case officer

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

Email

Sydney NSW 2001	Canberra ACT 2601	Melbourne VIC 3001
Brisbane QLD 4001	Adelaide SA 5001	Perth WA 6001
Hobart TAS 7001	Darwin NT 0801	

Ahpra & National Boards

Gender-based restrictions

Practitioner acknowledgement

Practitioner's details

Name

Monitoring & compliance number

Practitioner's declaration

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

- ☐ I am aware Ahpra may request and access from the senior person at each of my places of practice rosters, timesheets or similar information for the purposes of monitoring my compliance with the condition on my registration.
- ☐ I understand I am not permitted to practise until approved practice locations are published to the national public register.
- ☐ I have read and understood the requirements of the Gender-based restriction protocol.
- ☐ I understand the definition of 'patient', 'practice location', 'male', 'female' and 'contact' as detailed in the restriction on my registration.
- ☐ I am aware that to monitor my compliance with the gender-based restrictions Ahpra will:
  a. obtain Medicare data from Services Australia
  b. communicate with your patients, nominated booking staff and employers, and
  c. access, copy and/or retrieve appointment diaries, patient booking schedules, audit logs of electronic booking systems and the like from each approved place of practice.

Signature

Date

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

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Ahpra & National Boards

Gender-based restrictions

Nomination of practice locations

Practitioner's details

Name

Monitoring & compliance number

Practice location details

Place of practice 1

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 2

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 3

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 4

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 5

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 6

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 7

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Place of practice 8

Name of practice

For approval? (Yes or No) Maximum 3

Street address

Practitioner's declaration

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

- ☐ The details I have provided are true and accurate and represent all locations at which I was practising at the time of the imposition of the gender-based restriction.
- ☐ I have nominated a maximum of three practice locations to be considered for approval.
- ☐ I am aware that, for the purposes of the restriction on my registration and the Gender-based restriction protocol, 'practice location' means any location where a practitioner practises the profession and includes any place where a practitioner:
  a. is self-employed
  b. shares premises with other registered health practitioners
  c. is engaged by one or more entities under a contract of employment, contract for services or any other arrangement or agreement
  d. provides services for, or on the behalf of one or more entities, whether in an honorary capacity, as a volunteer or otherwise, whether or not the practitioner receives payment from an entity for the services, or
  e. the residential premises of a patient of the practitioner where the practitioner practises the profession.
- ☐ Upon publication of approved practice locations, I must only practice at those approved practice locations.

Signature

Date

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

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Ahpra & National Boards

Gender-based restrictions

Details of booking staff

Practitioner's details

Name

Monitoring & compliance number

Nominee's details

Nominee 1

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 2

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 3

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 4

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 5

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 6

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 7

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee 8

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Copy this page to submit more nominations

Practitioner's declaration

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

- ☐ This information is accurate and represents all staff at each approved practice location that are responsible for the booking of patient appointments.
- ☐ I have provided each nominated staff member with a copy of the Gender-based restriction protocol.
- ☐ The nomination of each staff member is accompanied by acknowledgement from each nominated staff member, on the approved form, that they are aware AHPRA will contact them and exchange information.

Signature

Date

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

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Ahpra & National Boards

Gender-based restrictions

Booking staff acknowledgement

Practitioner's details

Name

Monitoring & compliance number

Nominee's details

Name (Last, First)

Registration number (if registered)

Place of practice

Postal address

Contact number

Email

Nominee's declaration

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

- ☐ I have been provided with a copy of the Gender-based restriction protocol.
- ☐ I am aware that patients of the gender detailed in the restriction on the Practitioner's registration must be told at the time of attempting to book an appointment with the Practitioner or, in the case of an unbooked appointment at the time of presentation at the practice location seeking an appointment, that because of the restriction the appointment cannot be made.
- ☐ I am aware that that AHPRA may contact me to discuss the management of the Practitioner's restriction in the workplace.

Signature

Date

When completed, return this form to:

Case officer

Email

Ahpra
GPO Box 9958
IN YOUR CAPITAL CITY *(refer below)*

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