Medical Radiation Practice Board of Australia | AHPRA

Application to participate in the supervised practice program

Profession: **Medical radiation practice**

Part 7 Division 3 of the Health Practitioner Regulation National Law (the National Law)

This form is for medical radiation practitioners applying to participate in the supervised practice program prior to applying for general registration.

An applicant must have confirmed their supervised practice position and principal supervisor, and hold provisional registration or general registration with conditions that require a program of supervised practice.

You must complete and email this form with any required attachments to **mrpsupervisedpractice@ahpra.gov.au.** You must not commence practice until you have applied to the Board and been accepted to participate in the program.

It is important that you refer to the Board's *Supervised practice registration standard*, *Supervised practice guidelines* and the *Supervised practice program guide* before completing this declaration. These documents can be found at **www.medicalradiationpracticeboard.gov.au**

This application will not be considered unless it is complete and both the practitioner and their proposed principal supervisor meet the requirements identified in the Board's *Supervised practice registration standard.*

Privacy and confidentiality

The Board and AHPRA are committed to protecting your personal information in accordance with the *Privacy Act 1988* (Cth). The ways the Board and AHPRA may collect, use and disclose your information are set out in the collection statement relevant to this application, available at **www.ahpra.gov.au/privacy**.

By signing this form, you confirm that you have read the collection statement. AHPRA's privacy policy explains how you may access and seek correction of your personal information held by AHPRA and the Board, how to complain to AHPRA about a breach of your privacy and how your complaint will be dealt with. This policy can be accessed at **www.ahpra.gov.au/privacy**.

Symbols in this form

Additional information
Provides specific information about a question or section of the form.

Attention
Highlights important information about the form.

Signature required
Requests appropriate parties to sign the form where indicated.

Completing this form

- Read and **complete all questions**.
- Ensure that **all pages** are returned to AHPRA.
- Use a **black** or **blue** pen only.
- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒

SECTION A: Personal details

The information items in this section of the application marked with an asterisk (*) will appear on the public register.

1. What is your name?

Title* MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER SPECIFY

Family name*

First given name*

Middle name(s)*

Previous names known by (e.g. maiden name)

2. What is your registration number?

Registration number* M R P

SECTION B: Contact information

3. What are your contact details?

You may be contacted by AHPRA regarding your supervised practice.

These contact details should be the same as those you provided for your registration.

Provide your current contact details below – place an ☒ next to your preferred contact phone number.

Business hours ☐

Mobile ☐

After hours ☐

Email

SECTION C: Supervised practice program details

4. What is the name and address of the site of your supervised practice program?

If you are in a cluster (such as in Victoria) this is your host site.

Site/Building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town

State/Territory (e.g. VIC, ACT)

Postcode

5. When do you plan to commence supervised practice?

Commencement date

D D / M M / Y Y Y Y

SECTION D: Principal supervisor's details

6. What are the details of the registered medical radiation practitioner who will supervise the applicant?

If you are in a cluster (such as in Victoria) this is your host principal supervisor.

Provide principal supervisor details below

MR ☒ MRS ☒ MISS ☒ MS ☒ DR ☒ OTHER SPECIFY

Family (legal) name of supervisor

First given name

Registration number

M R P

Business phone

Mobile

Email

SECTION E: Declaration

I agree to participate in the supervised practice program for medical radiation practitioners according to the requirements contained in the *Supervised practice program guide*.

Name of applicant

Signature of applicant

SIGN HERE

Date

D D / M M / Y Y Y Y

Please email this form to:

mrpsupervisedpractice@ahpra.gov.au

You may contact the AHPRA on 1300 419 495 or you can lodge an enquiry at **mrpsupervisedpractice@ahpra.gov.au**

In the email subject line, please include your family name, first given name and registration number.
e.g. CITIZEN, John, MRP0001234567