



## Application to extend a 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 extend the length of their supervised practice program when they have not met the capability requirements necessary to apply for general registration. An applicant must have confirmed support for the proposed extension from their employer and principal supervisor, and hold provisional registration or general registration with conditions that require a program of supervised practice.

You and your principal supervisor must complete and email this form with any required attachments to [mrpsupervisedpractice@ahpra.gov.au](mailto:mrpsupervisedpractice@ahpra.gov.au). You may submit this application up to four weeks before your scheduled completion date.

The Board will consider the information provided in the form to decide if additional supervised practice is approved.

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](http://www.medicalradiationpracticeboard.gov.au)





 **This application will not be considered unless it is complete and both the practitioner and their 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](http://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](http://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.
-  **Attach document(s) to this form**  
Processing cannot occur until all required documents are received.
-  **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: 

## PART A – To be completed by the supervised practitioner

### 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

**Family name\***

**First given name\***

**Middle name(s)\***

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


#### 2. What is your registration number?

**Registration number\***



## 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 are you scheduled to complete supervised practice?**

**Scheduled completion date**  
 /  /

## SECTION D: Reason for extension of supervised practice

**6. What area(s) of medical radiation practice have you yet to demonstrate capability?**

 If your final assessment has not been submitted, please include areas you expect to be unable to demonstrate capability.

**Mark all options applicable to your application**

<input checked="" type="checkbox"/> Domain 1: professional and ethical conduct	<input checked="" type="checkbox"/> Domain 4: radiation safety and risk management
<input checked="" type="checkbox"/> Domain 2: professional communication and collaboration	<input checked="" type="checkbox"/> Domain 5: practice in medical radiation science (common) and either:
<input checked="" type="checkbox"/> Domain 3: evidence based practice and professional learning	<input checked="" type="checkbox"/> Domain 5a: practice in diagnostic radiography
	<input checked="" type="checkbox"/> Domain 5b: practice in nuclear medicine
	<input checked="" type="checkbox"/> Domain 5c: practice in radiation therapy


**7. What specific practice areas of each domain do you require additional supervised practice?**

.....

.....

.....

.....

 You **must** attach a separate sheet with additional details that do not fit in the space provided.



8. How many additional weeks of supervised practice is proposed?

The Board will consider this proposal in determining the number of weeks required.

Additional weeks of supervised practice proposed

9. Can this additional supervised practice be undertaken at the current site?

YES  [Go to question 11](#)

NO

Provide a detailed explanation below – then go to the next question



You **must** attach a separate sheet with additional details that do not fit in the space provided.

10. Has an alternative site been identified?

YES

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

NO



This application **cannot** be considered until an alternative site has been identified.

11. How will additional supervised practice allow you to demonstrate capability in all required domains?



You **must** attach a separate sheet with additional details that do not fit in the space provided.



## SECTION E: Supervised practitioner's declaration


I declare the information provided in this application is correct and if approved for an extension, 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 supervised practitioner <input type="text"/>	Signature of supervised practitioner  SIGN HERE
Date DD / MM / YYYY <input type="text"/> / <input type="text"/> / <input type="text"/>	

## PART B – To be completed by the principal supervisor

### SECTION F: Principal supervisor's comments


12. What are the details of the specific practice areas within each domain that the practitioner has yet to demonstrate capability?

 You **must** attach a separate sheet with additional details that do not fit in the space provided.

13. Do you support an extension of the supervised practice program?

YES  NO

**Provide details explaining why you do not support an extension of the supervised practice program**

 You **must** attach a separate sheet with additional details that do not fit in the space provided.

14. How many additional weeks of supervised practice is proposed?


 The Board will consider this proposal in determining the number of weeks required.

**Additional weeks of supervised practice proposed**

15. Can this additional supervised practice be undertaken at the current site?

YES  NO

**Provide details explaining why additional supervised practice cannot be undertaken at the current site**

 You **must** attach a separate sheet with additional details that do not fit in the space provided.



16. When is the additional supervised practice planned to commence?

Commencement date  
 /  /

17. Will you continue as the principal supervisor?

YES  NO

Provide the new principal supervisor's details below

Family (legal) name of new supervisor

First given name

Registration number

18. What is the extended supervision implementation plan proposed for the practitioner?

You **must** provide a weekly plan detailing the areas of practice to be undertaken during the proposed extension.

## SECTION G: Principal supervisor's declaration

I declare the information provided in this application is correct and if approved I will provide supervision and undertake the role of principal supervisor for the practitioner listed on this form according to the requirements contained in the *Supervised practice program guide*.

Name of principal supervisor <input style="width: 90%;" type="text"/>	Signature of principal supervisor <div style="border: 1px solid #ccc; padding: 10px; text-align: center;"> <span style="font-size: 2em; color: #ccc; opacity: 0.5;">SIGN HERE</span> </div>
Date <input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	

## SECTION H: Checklist

Have the following items been attached or arranged, if required/applicable?

<i>Additional documentation</i>		<b>Attached</b>
<b>Question 7</b>	A separate sheet with additional details of which practice areas the practitioner requires additional supervised practice	<input type="checkbox"/>
<b>Question 9</b>	A separate sheet with additional details explaining why additional supervised practice cannot be undertaken at the current site	<input type="checkbox"/>
<b>Question 11</b>	A separate sheet with additional details explaining how additional supervised practice will allow the practitioner to demonstrate capability in all required domains	<input type="checkbox"/>
<b>Question 12</b>	A separate sheet with additional details of the specific practice areas in which the practitioner has yet to demonstrate capability	<input type="checkbox"/>
<b>Question 13</b>	A separate sheet with additional details explaining why the principal supervisor does not support the extension of the practitioner's supervised practice program	<input type="checkbox"/>
<b>Question 15</b>	A separate sheet with additional details explaining why additional supervised practice cannot be undertaken at the current site	<input type="checkbox"/>
<b>Question 18</b>	A copy of the proposed extended supervision implementation plan	<input type="checkbox"/>

Please email this form with required attachments 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