




Request for change in circumstances for international medical graduates with limited or provisional registration

Profession: **Medical**

Health Practitioner Regulation National Law (the National Law)

This form is for international medical graduates who have limited or provisional registration and who wish to seek a variation in the circumstances of their registration.

It is important that you refer to the Board's registration standards before completing this application. Registration standards, codes and guidelines can be found at www.medicalboard.gov.au





 **This application will not be considered unless it is complete and all supporting documentation has been provided.** Supporting documentation **must** be certified in accordance with the Australian Health Practitioner Regulation Agency (Ahpra) guidelines. See *Certifying documents* in the *Information and definitions* section of this form.

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.
-  **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** and required **attachments** are returned to Ahpra.
- Use a **black or blue** pen only.
- Print clearly in **BLOCK LETTERS**
- Place X in **all** applicable boxes:
- **DO NOT send original documents.**

 Do not use staples or glue, or affix sticky notes to your application. Please ensure all supporting documents are on A4 size paper.

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 and date of birth?

Title*

MR MRS MISS MS DR OTHER

Family name*

First given name*

Middle name(s)*

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

Date of birth / /



If you have ever been formally known by another name, or you are providing documents in another name, you **must** attach proof of your name change unless this has been previously provided to the Board. For more information, see *Change of name* in the *Information and definitions* section of this form.

2. What is your registration number?

Registration number



Contact information

Once registered, you can change your contact information at any time.
Please go to www.ahpra.gov.au/login to change your contact details using your online account.

3. What are your contact details?

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

Business hours **Mobile**

After hours

Email

4. Has your mailing address changed?

YES

NO [Go to the next question](#)



Your mailing address is used for postal correspondence

Provide your new mailing address below

Site/building and/or position/department (if applicable)

Address/PO Box (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

State or territory (e.g. VIC, ACT)/International province Postcode/ZIP

Country (if other than Australia)

5. What is your registration pathway?

- Specialist pathway - specialist recognition
- Specialist pathway - area of need
- Specialist pathway - specialist recognition and area of need
- Short term training in a medical specialty pathway
- Competent Authority Pathway
- Standard Pathway

6. Are you changing pathway?



For more information, refer to www.medicalboard.gov.au/Registration/International-Medical-Graduates

YES

NO

You **must** attach evidence of eligibility for new pathway.

7. What date are you proposing the change to your circumstances takes effect?



You may only practise in accordance with the supervised practice position and supervisory arrangements approved by the Board while your request for a change in circumstances is being considered.

Date
 / /



SECTION B: Third party to act on behalf of applicant

i Under the *Privacy Act 1988* (Cth), the Board is generally not permitted to disclose personal information about an applicant to a third party. An applicant may authorise a third party (agent) to communicate with the Board and/or act on behalf of the applicant, by completing the following details.

8. Do you wish to appoint an agent to communicate/act on your behalf in relation to this application?
- YES Complete applicant authorisation and arrange for agent to complete agent authorisation
- NO Go to the next question

Applicant authorisation

i An agent can be an employer, sponsor, recruitment agent or any other individual authorised by the applicant to act on their behalf in relation to this application.

I authorise my agent to (mark one or more as required):

- communicate with the Board on my behalf regarding the processing and progress of my application. (The agent and the Board may communicate by telephone, fax, email, or written correspondence)
- undertake any other action reasonably necessary for the processing of my application on my behalf (except signing and lodging applications forms, which must be completed by the applicant), and
- receive all formal correspondence from the Board in relation to this application.

Date DD / MM / YYYY	Signature of applicant SIGN HERE
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Sponsor/Employer/Agent authorisation

AGENT TO COMPLETE: I consent to act as agent of the registrant named below.

Full name of agent

Full name of applicant

Agent contact details

Address/PO Box (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

State or territory (e.g. VIC, ACT)/International province

Postcode/ZIP

Country

Business hours

Mobile

Email

Date DD / MM / YYYY	Signature of agent SIGN HERE
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SECTION C: Type of change in circumstances

9. Why are you applying for a change in circumstances?

Mark all options applicable to your application

I am proposing to change, remove or add work sites for my current position
Go to section D: Changing, adding or removing work sites for your current position

I am:

- proposing to work in a new position with a new employer or existing employer
- requesting a change to my current supervision level, or
- proposing a change of supervisor(s)

Go to section E: Changes to supervision arrangements and/or employment

My change in circumstances involve other changes to my current position
 e.g. minor changes to your current responsibilities, a request to extend your period of short-term training in a medical specialty
Go to section F: Other proposed changes to your current position

SECTION D: Changing, adding or removing work sites for your current position

10. Are you requesting to add a temporary work site to your current position so that you can fulfil requirements for upskilling or clinical assessment?

YES NO

i You may be required to fulfil upskilling or clinical assessment requirements of a college or on the recommendation of a PESCI panel or on the recommendation of your supervisor.

You **must** attach:

- if applicable, a letter from the relevant specialist medical college confirming the upskilling and clinical assessment required to be completed to fulfil requirements of the specialist pathway – specialist recognition and the duration of the upskilling or clinical assessment
- a supervised practice plan for the temporary work site, and
- a work performance report that covers the period since your last report, if there is gap between your last report and lodgement of your request for a change in circumstances.

If your supervisor is recommending upskilling or clinical assessment, the work performance report should confirm the purpose of the upskilling or clinical assessment required and the duration of the upskilling or clinical assessment. If this information is not included in your work performance report, you must attach a letter from your supervisor confirming this information.

11. Are you requesting to change, add or remove work sites for your current employer?

YES NO

i If you are removing work sites, you may be required to provide supporting documentation if the removal of sites will have an impact on your current supervision arrangements and level of support available. Ahpra will advise you whether you are required to provide any supporting documentation.

Site 1

Type of site (mark only one)

Additional or new site Removal of sites

Site address

Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Postcode

Contact person

Opening hours : : to : :



Site 2

Type of site (mark only one)

Additional or new site Removal of sites

Site address

Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Contact person Opening hours : : to : :

Site 3

Type of site (mark only one)

Additional or new site Removal of sites

Site address


Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Contact person Opening hours : : to : :

 Attach a separate sheet if all your proposed changes do not fit within the space provided.



You **must** also attach:

- a work performance report that covers the period since your last report, if there is gap between your last report and lodgement of your request for a change in circumstances
- a new/revised supervised practice plan for any new or additional location(s)
- a new/revised position description, if the change to your location(s) has an impact on the original position description previously approved by the Board, and
- a new/revised training plan, if the change to your location(s) will change the training plan previously approved by the Board.

If you are in any of the pathways listed below, you may also need to attach or organise additional documents.

Specialist pathway – specialist recognition

The Board may require a letter from the relevant specialist medical college confirming support for your change in circumstances and providing advice on whether any change to your position or training plan is appropriate. Ahpra will advise whether a letter from the college is required.

Short-term training in a medical specialty pathway

You **must** submit a letter from the relevant specialist medical college confirming support for your change in circumstances and providing an assessment of your suitability for the training position based on your proposed changes.

Limited registration for an area of need

If the change in location(s) extends beyond the geographical area and/or type of health service stated in the area of need declaration from the Minister of Health or delegate originally provided to the Board, you must attach a further area of need declaration for the new/additional location(s) (excludes practitioners who are seeking to add a temporary work site for a short period for the purposes of fulfilling specialist college requirements).

Proposing to work in a general practice position

You may be required to complete a pre-employment structured clinical interview (PESCI) for the new sites. (Standard pathway or Competent Authority applicants) Ahpra will advise whether you are required to complete a PESCI.

12. Will your principal place of practice change as a result of your proposed changes to work sites?

YES

NO

Provide the address of your proposed principal place of practice below

Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Postcode

Contact person

Opening hours

: to :

13. Will the proposed changes to your work site(s) result in a change of principal supervisor or co-supervisors?

YES *Go to question 14*

NO *Go to Section G: Declarations*



SECTION E: Changes to supervision arrangements and/or employment

14. Are you proposing a change to your principal supervisor or co-supervisor(s) for your current position?

YES

NO *Go to the next question*



For more information refer to, www.medicalboard.gov.au/Registration/International-Medical-Graduates/Supervision

Provide the details of your updated supervision structure

Name of principal supervisor

Registration number

M E D

Position

Email

Business contact phone number

Work address

Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Postcode

Co-supervisors details (if applicable)

Name of co-supervisor

Registration number

M E D

Position



If the requested change in supervision affects your supervised practice plan as previously approved by the Board, you must complete and attach a revised supervised practice plan in accordance with the Board's supervised practice guidelines.

You **must** attach a separate sheet if the updated supervision structure details do not fit within the space provided.



15. Are you requesting a change to your currently approved supervision level?

YES

NO Go to the next question

Provide the details of the change you are requesting

Your current supervision level

Your proposed supervision level

Provide the reasons why the proposed change is appropriate

You **must** attach a work performance report which includes your principal supervisor's recommendation for a change to supervision level and a revised supervised practice plan.

16. Are you proposing to work in a new position with a new employer or an existing employer?

YES

NO Go to Section G: Declarations

You **must** attach:

- your offer of employment
- a list of proposed work sites (if not already included in your offer of employment), which identifies your new principal place of practice and all sites you will be working at as part of your new position. Your list of proposed work sites must include the facility name, address and contact details for each site
- your position description
- a work performance report that covers the period since your last report, if there is gap between your last report and lodgement of your request for a change in circumstances
- a training plan (if applicable), and
- a supervised practice plan completed in accordance with the Board's *Guidelines – Supervised practice for international medical graduates*.

If you are in any of the pathways listed below you may also need to attach or organise additional documents.

Specialist pathway - specialist recognition

The Board may require a letter from the relevant specialist medical college confirming support for your change in circumstances and providing advice on whether any change to your position or training plan is appropriate. Ahpra will advise whether a letter from the college is required.

Short-term training in a medical specialty pathway

You **must** submit an *Application for assessment by a specialist medical college – AAMC-30*. The college will provide the outcome of your assessment to the Board.

Limited registration for an area of need

You **must** provide an area of need declaration from the Minister of Health or delegate for the geographical area and/or type of health service stated in the area of need.

Proposing to work in a general practice position

You may be required to complete a pre-employment structured clinical interview (PESCI) for the new position. (Standard pathway or Competent Authority applicants) Ahpra will advise whether you are required to complete a PESCI.

17. Is your new position in general practice?

YES Go to the next question

NO Go to Section G: Declarations

18. Do you hold limited registration for area of need?

The Board's registration standard for limited registration for area of need requires applicants seeking to work in general practice to have three years (full time equivalent) experience working in general practice or primary care.

YES Go to the next question

NO Go to question 22



19. Is this the first time you will be working in general practice in Australia?

YES Go to the next question

NO If you do not have the required experience in general practice, you may be required to have your experience assessed and provide further information.
Go to question 22

20. How many years (full time equivalent) experience have you had working in general practice or primary care?

Years of (full time equivalent) experience

21. Have you had your experience assessed by the:

- Australian College of Rural and Remote Medicine (ACRRM), or
- Royal Australian College of General Practitioners (RACGP)?

i If you have had your experience formally assessed by the RACGP or ACRRM for another reason, you will not require further assessment of your experience by the Board. You will need to attach evidence from the college that confirms you have at least three years (full-time equivalent) experience working in general practice or primary care. If the college has not assessed your experience, the Board will assess your experience.

YES



You **must** attach evidence from the ACRRM or the RACGP confirming your experience working in general practice or primary care.

NO

The Board will assess your experience. Choose the appropriate option below.

I have been **employed in general practice or primary care**



You **must** attach letter(s) from organisations where you were/are employed demonstrating that you have had at least a total of three years (full-time equivalent) experience in general practice or primary care.

The letter(s) must:

- be on the organisation's letterhead
- be signed and dated by the Senior Medical Director, Principal, Practice Manager (or equivalent)
- include the contact details for the person that signed the letter and confirmed your experience (phone number, employment address and email address)
- confirm that you were/are employed by the organisation
- confirm your position title and position description
- confirm the dates you were/are employed
- confirm the hours you worked per week (full time or part time)
- state the nature of your work and the scope of your clinical activities
- state the types of patients seen by you and a description of the range of illnesses presented.

I have been in **solo practice or am/was self-employed**



You **must** attach:

- Your curriculum vitae include:
 - your responsibilities in general practice or primary care including whether you worked part-time or full-time
 - the hours worked per week
 - the dates your medical practice is/was in operation
 - the nature of your work and the scope of your clinical activities, and
 - the types of patients seen by you and the range of illnesses presented.
- evidence of licensure or accreditation (if the country where your medical practice is/was located requires your medical business to be licensed or accredited)
- five patient referrals (de-identified) that you have made to specialist practitioners, and
- three references from specialist practitioners that you have referred patients to, confirming your experience in general practice or primary care. The references must include the specialist practitioners contact details including phone, street address and email address.

The Board may request further information, if the information you have provided does not adequately verify your experience.



22. Who are the current doctors working at the practice?

i For the general practice where you are proposing to work.

Current doctor
Name

Registration number Sessions per week

Current doctor
Name

Registration number Sessions per week

Current doctor
Name

Registration number Sessions per week

Current doctor
Name

Registration number Sessions per week

23. What are the details of the nurses and other staff?

i For the general practice where you are proposing to work.

List number of other staff, job title and whether full-time or part-time

Job title	Number of staff	Full-time	Part-time / Casual

Attach a separate sheet if the details do not fit in the space provided.

24. Generally, what are the details of registered patients?

i For the general practice where you are proposing to work.

List details below – then go to Section G: Declarations

Number of patients General age

Ethnic background



SECTION F: Other proposed changes to your current position

25. Are you requesting to extend your period of short-term training (for your current position) beyond the specified period of training previously approved by the Board?

YES

NO

You **must** attach a letter from the relevant specialist medical college confirming support for your change in circumstances and providing an assessment of your suitability for the training position based on the proposed change(s).

26. Are you requesting other changes to your circumstances for your current position?

YES

NO **Go to Section G: Declarations**

Dependent on the type of change, Ahpra will advise you whether any supporting documentation is required to ensure safe practice.

Provide details of the proposed changes to your current circumstances

Attach a separate sheet if all your proposed changes do not fit within the space provided.

SECTION G: Declarations

Before you sign and date this form, make sure that you have answered all the relevant questions correctly and read the statements below. An incomplete form may delay processing and you may be asked to complete a new form.

Principal supervisor's undertaking – *To be completed and signed by the principal supervisor and co-supervisor*

I undertake to be the applicant's principal supervisor, to provide supervision in accordance with the Board's Guidelines and to provide a level of supervision as stated in accordance with the Board approved supervision plan and as otherwise determined from time to time by the Board.

I further agree to:

- ensure as far as possible, that the IMG is practising safely and is not placing the public at risk
- observe the IMG's work (or where applicable, delegate the observation of day-to-day work to appropriately qualified co-supervisors), conduct case reviews, periodically conduct performance reviews and address any problems that are identified
- ensure that any term co-supervisors that I appoint that are delegated the day-to-day supervision meet the requirements set in the Board's guidelines (this is only applicable to DMS or DCT (or equivalent) in a hospital setting)
- ensure before I delegate supervision to a temporary co-supervisor, that he/she has general and/or specialist registration and is appropriately experienced to provide the supervision
- notify the Board immediately if I have concerns about the IMG's clinical performance, health or conduct or if the IMG fails to comply with conditions, undertakings or requirements of registration
- ensure that the IMG practises in accordance with work arrangements approved by the Board
- ensure that Board approval has been obtained for any proposed changes to supervision or work arrangements before they are implemented
- inform the Board if I am no longer able or willing to undertake the role of the IMG's supervisor
- provide reports to the Board in a form approved by the Board including an orientation report and a work performance report after three months initial registration and work performance reports at renewal or new application or at subsequent intervals as determined by the Board
- complete the online education and assessment module, if not previously completed (login details will be provided after the supervision arrangements have been approved).

<p>Name of principal supervisor</p> <input style="width: 90%;" type="text"/> <p>Date</p> <input style="width: 20%; text-align: center;" type="text"/> / <input style="width: 20%; text-align: center;" type="text"/> / <input style="width: 50%; text-align: center;" type="text"/>	<p>Signature of principal supervisor</p> <div style="border: 1px solid #ccc; padding: 5px; text-align: center;"> SIGN HERE </div>
<p>Name of co-supervisor</p> <input style="width: 90%;" type="text"/> <p>Date</p> <input style="width: 20%; text-align: center;" type="text"/> / <input style="width: 20%; text-align: center;" type="text"/> / <input style="width: 50%; text-align: center;" type="text"/>	<p>Signature of co-supervisor</p> <div style="border: 1px solid #ccc; padding: 5px; text-align: center;"> SIGN HERE </div>



Applicant's declaration – To be completed and signed by the applicant

I confirm that I have read the privacy and confidentiality statement for this form.

I acknowledge that:

- notices required under the National Law and other correspondence relating to my application and registration (if granted) will be sent electronically to me via my nominated email address, and
- Ahpra uses overseas cloud service providers to hold, process and maintain personal information where this is reasonably necessary to enable Ahpra to perform its functions under the National Law. These providers include Salesforce, whose operations are located in Japan and the United States of America.

I declare that:

- the information provided in this document is true and correct, and
- I am the person named in this application and in the documents provided.

I confirm that I am authorised to provide the personal details contained in this form.

I consent to my personal details and information being checked by a third party system to verify and confirm my identity.

I confirm that I am aware and approve of the requested change related to my medical registration.

<p>Name of applicant</p> <input style="width: 95%;" type="text"/> <p>Date</p> <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 50%; text-align: center;" type="text"/>	<p>Signature of applicant</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> SIGN HERE </div>
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Employer sponsor declaration – To be completed and signed by the employer sponsor

27. What are the details of the employer sponsor?

The employer sponsor must be a medical practitioner.

Name of employer sponsor (must be a medical practitioner)	
<input style="width: 95%;" type="text"/>	
Email	
<input style="width: 95%;" type="text"/>	
Business contact phone number	M E D
<input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>	<input style="width: 50%;" type="text"/>
Registration number	
<input style="width: 95%;" type="text"/>	
Site/building (if applicable)	
<input style="width: 95%;" type="text"/>	
Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)	
<input style="width: 95%;" type="text"/>	
<input style="width: 95%;" type="text"/>	
<input style="width: 95%;" type="text"/>	
<input style="width: 95%;" type="text"/>	
City/Suburb/Town	
<input style="width: 95%;" type="text"/>	
State or territory (e.g. VIC, ACT)/International province	Postcode/ZIP
<input style="width: 50%;" type="text"/>	<input style="width: 40%;" type="text"/>

I declare that the information provided in this document is true and correct.

I confirm that the medical practitioner relevant to this application is aware and approves of the requested change in the circumstances of their medical registration.

<p>Name of employer sponsor</p> <input style="width: 95%;" type="text"/> <p>Date</p> <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 50%; text-align: center;" type="text"/>	<p>Signature of employer sponsor</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> SIGN HERE </div>
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28. Have the details of your sponsor contact changed?

YES

NO



A sponsor contact person (e.g. the name of the human resource manager/practice manager) and email address must be provided for receipt of correspondence.

Name of sponsor organisation

Title of sponsor contact

MR MRS MISS MS DR OTHER

Family name of sponsor contact

First given name of sponsor contact

Position title of sponsor contact

Email

Business hours contact phone number

Site/building (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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

Postcode



SECTION H: Checklist

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

<i>Additional documentation</i>		Attached
Question 1	Evidence of a change of name	<input type="checkbox"/>
Question 6	Evidence of eligibility for new pathway	<input type="checkbox"/>
Question 10	A letter from the relevant specialist medical college confirming the upskilling and clinical assessment required	<input type="checkbox"/>
Question 10	A supervised practice plan for the temporary work site	<input type="checkbox"/>
Question 10	Your most recent work performance report (if not previously provided to the Board)	<input type="checkbox"/>
Question 11	A separate sheet with additional details of your proposed site changes	<input type="checkbox"/>
Question 11	Your most recent work performance report (unless previously provided to the Board)	<input type="checkbox"/>
Question 11	A new/revised supervised practice plan for any new or additional location(s)	<input type="checkbox"/>
Question 11	A new/revised position description	<input type="checkbox"/>
Question 11	A new/revised training plan	<input type="checkbox"/>
Question 11	Additional documents relevant to your pathway have been attached to the form or requested from the relevant authority	<input type="checkbox"/>
Question 14	A revised supervised practice plan	<input type="checkbox"/>
Question 14	A separate sheet with additional details of your updated supervision structure	<input type="checkbox"/>
Question 15	A work performance report which includes your principal supervisor's recommendation for a change to supervision level and a revised supervised practice plan	<input type="checkbox"/>
Question 16	A copy of your offer of employment	<input type="checkbox"/>
Question 16	A list of proposed work sites (if not already included in your offer of employment)	<input type="checkbox"/>
Question 16	Your position description	<input type="checkbox"/>
Question 16	Your most recent work performance report (unless previously provided to the Board)	<input type="checkbox"/>
Question 16	A training plan	<input type="checkbox"/>
Question 16	A supervised practice plan	<input type="checkbox"/>
Question 16	Additional documents relevant to your pathway have been attached to the form or requested from the relevant authority	<input type="checkbox"/>
Question 21	Evidence from the ACRRM or the RACGP confirming your experience working in general practice or primary care	<input type="checkbox"/>
Question 21	Letter(s) from organisations where you were/are employed demonstrating that you have had three years (full-time equivalent) experience in general practice or primary care	<input type="checkbox"/>
Question 21	Evidence of licensure or accreditation	<input type="checkbox"/>
Question 21	Five de-identified patient referrals that you have made to specialist practitioners	<input type="checkbox"/>
Question 21	Three references from specialist practitioners that you have referred patients to	<input type="checkbox"/>
Question 23	A separate sheet with additional details of the nurses and other staff working at the practice	<input type="checkbox"/>
Question 25	A letter from the relevant specialist medical college confirming support for your change in circumstances	<input type="checkbox"/>
Question 26	A separate sheet with additional details of other changes to your circumstances requested	<input type="checkbox"/>



Do not email this form.

Please submit this completed form and supporting evidence using the Online Upload Service at www.ahpra.gov.au/registration/online-upload.
You may contact Ahpra on 1300 419 495



Information and definitions

CERTIFYING DOCUMENTS

DO NOT send original documents.

Copies of documents provided in support of an application, or other purpose required by the National Law, must be certified as true copies of the original documents. Each and every certified document **must**:

- be in English. If original documents are not in English, you must provide a certified copy of the original document and translation in accordance with Ahpra guidelines, which are available at www.ahpra.gov.au/registration/registration-process
- be initialled on every page by the authorised officer. For a list of people authorised to certify documents, visit www.ahpra.gov.au/certify.aspx
- be annotated on the last page as appropriate e.g. 'I have sighted the original document and certify this to be a true copy of the original' and signed by the authorised officer,
- for documents containing a photograph, the following certification statement must be included by the authorised officer, 'I certify that this is a true copy of the original and the photograph is a true likeness of the person presenting the document as sighted by me', along with their signature, and
- list the name, date of certification, and contact phone number, and position number (if relevant) and have the stamp or seal of the authorised officer (if relevant) applied.

Certified copies will only be accepted via the Online Upload Service at www.ahpra.gov.au/registration/online-upload. Photocopies of previously certified documents will not be accepted. For more information, Ahpra's guidelines for certifying documents can be found online at www.ahpra.gov.au/certify.aspx

CHANGE OF NAME

If you are providing documents in another name to that currently recorded on the Register of Medical Practitioners, you must attach proof of your name change unless this has been previously provided to the Board.

Evidence must be a certified copy of one of the following documents:

- Standard marriage certificate (ceremonial certificates will not be accepted).
- Deed poll.
- Change of name certificate.

Faxed, scanned or emailed copies of certified documents will not be accepted.

PRACTICE

Practice means any role, whether remunerated or not, in which you use your skills and knowledge as a health practitioner in your profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of services in the profession.