



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.



Attentior

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 SPECIFY								
Family name*								
First given name*								
Middle name(s)*								
Previous names known by (e.g. maiden name)								
Date of birth DD / MM / YYYYY								
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 <i>Change of name</i> in the <i>Information and definitions</i> section of this form.								

2. What is your registration number?

R	egistration r	umber			
	M E D				
(-					



Contact information

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													
. Has your mailing address changed?	YES Go to the next question Provide your new mailing address below													
Your mailing address is used														
for postal correspondence	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)													
	Address/FO Box (e.g. 123 Jaivies avenue, of old 14, 30 Jaivies Street, of FO Box 1234)													
	City/Suburb/Town													
	State or territory (e.g. VIC, ACT)/International province Postcode/ZIP													
	Cate of territory (e.g. 110,71017/micritational province													
	Country (if other than Australia)													
	Southly (it states a teath resource)													
. What is your registration	Specialist pathway - specialist recognition													
pathway?	Specialist pathway - specialist recognition Specialist pathway - area of need													
	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													
. 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.													
. What date are you proposing the change	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.													
to your circumstances	Date													
takes effect?														

SECTION B: Third party to act on behalf of applicant



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?



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.

YES 🔀	Complete applicant authorisation and arrange for agent to complete agent authorisation
NO 🔀	Go to the next question

Applicant authorisation

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 / Y Y Y Y	Signature of applicant SIGN HERE						

Sponsor/Employer/Agent authorisation

AGENT TO COMPLETE: I consent to act as agent of the	renistrant named helow							
Full name of agent	rogistrant named below.							
Full name of applicant								
Agent contact details								
Address/P0 Box (e.g. 123 JAMES AVENUE; or UNIT 1A, 30	JAMES STREET; or PO BOX 1234)							
City/Suburb/Town								
City/Suburb/Towii								
	Declarate (700							
State or territory (e.g. VIC, ACT)/International province	Postcode/ZIP							
Country								
Business hours	Mobile							
Email								
Dete	Cimphun of poort							
Date	Signature of agent							
	SIGN HERE							

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 in a medical specialty Go to section F: Other proposed changes to your current position	training

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?



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

NO

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 position with your current employer?



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											
Site address											
Site/building (if applicable)											
Address (e.g. 123 JAMES AVE	NUE; or UNIT 1A, 30 JAMES S	STREET; or PO BOX 1234)									
City/Suburb/Town											
State/Territory (e.g. VIC, ACT)		Postcode									
Contact person		Opening hours									
		HH:MM to	H H : M M								

Type of site (mark only one)													
Additional or new site	X Rem	oval of s	ites										
Site address													
Site/building (if applicable)													
Address (e.g. 123 JAMES AVENUE; or UNIT 1A,	S STREE	T; or PO	вох	1234	4)								
													=
City/Suburb/Town													
State/Territory (e.g. VIC, ACT)		Post	Postcode										
				Ш									
Contact person		Ope	ning hou	rs	л .				7 [N /	D //		
		J H	H :	IVI I\	/1	to	Н	Н]:	M	IVI		
Site 3 Type of site (mark only one)													
	X Rem	oval of s	ites										
Additional or new site Removal of sites													
		0.0											
Site address Site/building (if applicable)													
Site address													
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Site address Site/building (if applicable)	30 JAME			BOX	1234	4)							
Site address	30 JAME			ВОХ	1234	4)							
Site address Site/building (if applicable)	30 JAME			ВОХ	1234	4)							
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Site address Site/building (if applicable)	30 JAME			вох	11234	4)							
Site address Site/building (if applicable)	30 JAME			BOX	1234	4)							
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A,	30 JAME			BOX	1234	4)							
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A,	30 JAME	ES STREE		BOX	11234	4)							
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A, City/Suburb/Town	30 JAME	ES STREE	ET; or PO	BOX	1234	4)							
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A, City/Suburb/Town	30 JAME	Post	ET; or PO		1234	4)							
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A, City/Suburb/Town State/Territory (e.g. VIC, ACT)	30 JAME	Post	code			4) to	H		7:1	M	M		
Site address Site/building (if applicable) Address (e.g. 123 JAMES AVENUE; or UNIT 1A, City/Suburb/Town State/Territory (e.g. VIC, ACT)	30 JAME	Post	code	rs]:[IM	M		



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



YES X

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

NO X

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?

\rightarrow	
Provide the address of your proposed pr	rincipal 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/Cuburb/Tours	
City/Suburb/Town	
State/Territory (e.g. VIC, ACT)	Postcode
Contact person	Opening hours
	HIH: MIM to HIH: MIM

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

YES X

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



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

Registration	number																					
M E D									L													
Position Email																						
Business co	ntact ph	one nui	mber																			
Work addre Site/building		cable)												1								
Address (e.	g. 123 J <i>A</i>	MES A	VENUE	; or l	JNIT	1A,	30 .	JAME	S ST	REE	T; 01	r PO	ВОХ	(12	34)							
City/Suburb	/Town		<u> </u>																			
State/Territo Co-supervi Name of co-	sors det	ails (if		cable	!)				[Posto	code)										
Registration									F	Posit	ion											
M E D																						
	f the rec approve in accor You mus	d by th dance	ne Boa with t	ard, y the E	ou Boar	mus d's s	st co supe	mpl ervis	ete a ed p	and ract	atta tice	ach gui	a re delii	vise nes.	d sı	uper	vise	d pı	acti	се р	lan	

Go to the next question

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

YES	>	<
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N0

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?





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. Are you seeking a PESCI exemption?

YES X

NO

19. 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.



Go to the next question



Go to question 23

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



Go to the next question

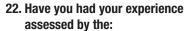


If you do not have the required experience in general practice, you may be required to have your experience assessed and provide further information.

Go to question 23

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

Years of (full time equivalent) experience





Royal Australian College of General Practitioners (RACGP)?



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.





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





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
- 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.

I am on the RACGP FSP I have been accepted for the RACGP FSP I have applied for the RACGP FSP			
Mark all that apply RACGP Standards for general practices (latest edition) RACGP Standards for general practice training (latest edition)			
YES NO			
Current doctor Name Registration number Current doctor Name Registration number Sessions per week MED Current doctor Name Registration number Sessions per week MED Current doctor Name Sessions per week Current doctor Name			
Current doctor Name Registration number M E D Sessions per week			
List number of other staff, job title and whether full-time or part-time			Part-
Attach a separate sheet if the details do not fit in the space provide	of staff	Full-time	time / Casual
	I have been accepted for the RACGP FSP I have applied for the RACGP FSP NO Mark all that apply RACGP Standards for general practices (latest edition) RACGP Standards for general practice training (latest edition) VES NO Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D List number of other staff, job title and whether full-time or part-time Job title	I lam on the RACGP FSP I have been accepted for the RACGP FSP I have applied for the RACGP FSP I have applied for the RACGP FSP Wark all that apply RACGP Standards for general practices (latest edition) RACGP Standards for general practice training (latest edition) Current doctor Name Registration number Sessions per week MED Current doctor Name Registration number Registration number Registration number Sessions per week MED Current doctor Name Registration number Registration number Sessions per week MED Current doctor Name Registration number Registration number Sessions per week MED Current doctor Name Registration number Sessions per week MED Current doctor Name Registration number Sessions per week MED Current doctor Name Registration number	I have been accepted for the RACGP FSP I have applied for the RACGP FSP I have applied for the RACGP FSP YES NO Mark all that apply RACGP Standards for general practices (latest edition) RACGP Standards for general practice training (latest edition) YES NO Current doctor Name Registration number Registration number Sessions per week M E D Current doctor Name Registration number Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D Current doctor Name Registration number Sessions per week M E D List number of other staff, job title and whether full-time or part-time

ACCL-30	
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28.	Generall	y, what are t	the
	details o	of registered	patients?



For the general practice where you are proposing to work.

List details below – then	to Section G: Declarations	
Number of patients	General age	
Ethnic background		

SECTION F: Other proposed changes to your current position

29. 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?



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).

Go to Section G: Declarations

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



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

ES 📉	N
Provide	details of the proposed change

es to your current circumstances

ı	
ı	
ı	101

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).

Name of principal supervisor Date DD / MM / YYYYY	Signature of principal supervisor SIGN HERE
Name of co-supervisor Date DID / MM / YYYYY	Signature of co-supervisor SIGN HERE

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.

Name of applicant	Signature of applicant
Date	SIGN HERE
DD/MM/YYYY	JES CICITATILITIE

Employer sponsor declaration – *To be completed and signed by the employer sponsor*

31. What are the details of the employer sponsor?



The employer sponsor must be a medical practitioner.

usiness contact phone number	M	E D			
egistration number te/building (if applicable)					
ddress (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 J	AMES STREET	; or PO BO	X 1234)		
ty/Suburb/Town					

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.

Name of employer sponsor	Signature of employer sponsor
Date DD / MM / Y Y Y Y	SIGN HERE

32. Have the details of your sponsor contact changed?



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.

ES 🔀			N	0 🔀								
Name of s	ponsor orga	nisation										
MR 🔀	onsor conta MRS MRS	MISS	MS ct	\boxtimes	DR 📐		OTHEF	?	SPECI	FY		
First giver	name of sp	onsor co	ntact									
Position ti	tle of spons	or contac	et									
Email												
	hours conta		number									
Address (6	e.g. 123 JAM	ES AVENU	JE; or UNIT	1A, 30	JAMES	STRE	ET; or	PO BO	(1234)			
City/Subu	rb/Town											
State/Terr	itory (e.g. VI	C, ACT)					Postc	ode				



SECTION H: Checklist

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

Additional dod	eumentation	Attached
Question 1	Evidence of a change of name	X
Question 6	Evidence of eligibility for new pathway	X
Question 10	A letter from the relevant specialist medical college confirming the upskilling and clinical assessment required	X
Question 10	A supervised practice plan for the temporary work site	\times
Question 10	Your most recent work performance report (if not previously provided to the Board)	\times
Question 11	A separate sheet with additional details of your proposed site changes	\times
Question 11	Your most recent work performance report (unless previously provided to the Board)	X
Question 11	A new/revised supervised practice plan for any new or additional location(s)	\times
Question 11	A new/revised position description	\times
Question 11	A new/revised training plan	\times
Question 11	Additional documents relevant to your pathway have been attached to the form or requested from the relevant authority	X
Question 14	A revised supervised practice plan	X
Question 14	A separate sheet with additional details of your updated supervision structure	X
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	\boxtimes
Question 16	A copy of your offer of employment	X
Question 16	A list of proposed work sites (if not already included in your offer of employment)	X
Question 16	Your position description	X
Question 16	Your most recent work performance report (unless previously provided to the Board)	\times
Question 16	A training plan	\times
Question 16	A supervised practice plan	\times
Question 16	Additional documents relevant to your pathway have been attached to the form or requested from the relevant authority	\times
Question 22	Evidence from the ACRRM or the RACGP confirming your experience working in general practice or primary care	X
Question 22	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	\boxtimes
Question 22	Evidence of licensure or accreditation	X
Question 22	Five de-identified patient referrals that you have made to specialist practitioners	\times
Question 22	Three references from specialist practitioners that you have referred patients to	X
Question 27	A separate sheet with additional details of the nurses and other staff working at the practice	\times
Question 29	A letter from the relevant specialist medical college confirming support for your change in circumstances	X
Question 30	A separate sheet with additional details of other changes to your circumstances requested	X

1 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

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CERTIFYING DOCUMENTS

Information and definitions

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.