

**Form Number SE-10**

**Restricted scope of practice – Specialist registration only**

**Medical Board of Australia**

Practitioner Details

By signing this form I acknowledge and confirm:

1. I am aware that I am only permitted to practise within the scope of practice as set out in the restrictions on my registration.
2. I am aware that for the purposes of monitoring my compliance with the restrictions on my registration, AHPRA may obtain or receive information from relevant authorities (such as but not limited to Medicare).

Practitioner’s declaration

Name

(Last, First)

Monitoring & Compliance number

Signature

Date

Return form to

Post

Email

Case officer