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| **Approval Authority** | Naomi Heinrich - Chief Operating Officer CAHS;Michelle McKay - Chief Operating Officer TEHS; |
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| This is a NT Health Policy Guidelines Centre (PGC) Approved and Controlled document. Uncontrolled if printed. |

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| **Applicant Details** |
| Given Names:  |       | Surname: |       |
| Postal Address: |       |
| Work Unit:  |       | Email Address: |       |
| Phone:  |       | Mobile: |       |

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| **Registration Details** |
| [ ]  Initial Application | [ ]  Application for Change in Prescriber Level |
| **1. Professional Qualification** |
| **Clinicians must have the stipulated professional qualification to prescribe from equipment categories.** Refer to Application Requirements and the TEP AP-1 Professional Criteria for Approved Prescribers. |
| [ ]  Occupational Therapy | [ ]  Physiotherapy |
| [ ]  Speech Pathology | [ ]  Registered Nurse |
| **1a. Nominated Equipment Prescription Category (Please select as relevant)** |
| **Equipment Category** | **Level 1 General** | **Level 2 General** | **Level 2 Seating** |
| Communication Aids and Devices | [ ]  | [ ]  | [ ]  |
| Aids for Daily Living | [ ]  | [ ]  | N/A |
| Bed Equipment | [ ]  | [ ]  | N/A |
| Pressure Management Equipment | [ ]  | [ ]  | [ ]  |
| Wheeled Mobility Aids | [ ]  | [ ]  | [ ]  |
| Ambulant Mobility Aids  | [ ]  | [ ]  | N/A |
| Personal Emergency Response System | [ ]  | N/A | N/A |
| Home Modifications | [ ]  | [ ]  | N/A |
| Other:  | Oxygen | [ ]  | [ ]  | N/A |
|  | Continence | [ ]  | [ ]  | N/A |
| *If you are applying for any ‘LEVEL 1’ or ‘Other’ Equipment Category for your* ***Professional Qualification only****, please proceed to Section 3. Applicant Declaration.* |

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| **2. Level 2 General and/Level 2 Seating Prescriber Recognition** |
| If you wish to be recognised as a Level 2 General, Level 2 Seating Prescriber, and/or a Prescriber for specific equipment categories outside your professional qualification please complete the following. |
| **2a. Clinical Experience Statement** |
| Please provide details of experience prescribing within each nominated equipment category. Refer to the TEP AP-1 Professional Criteria for Approved Prescribers, Table 1: Equipment Groups, for professional criteria details.Only one place of employment required per equipment category if 3+ prescriptions completed in that place of work. |

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| **Equipment Category****(Level 2 Only)** | **Place Of Work/Employer** | **Role** | **Paediatric / Adult** | **Years In Role** | **No. of Prescriptions** |
| *eg. ADL* | *Ballarat Hospital* | *OT Clinician* | *Adult* | *5* | *50+* |
|       |       |       |       |       |       |
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| **2b. Professional Development** |
| * If applicable, outline any further education and training you have undertaken specifically relating to the equipment category/categories you have nominated (include any relevant formal qualifications):

List education and training sessions you have attended. Include details such as title, type, date. For example:* *Advanced and Half Day Ramp workshop conducted by Liz Ainsworth (21st and 2nd March 2012)*
* *Pressure care in-service by SEAT Clinical Leader including demonstration on use of pressure mapping technology (2011)*
* *Trade exhibitions and information sessions presented by Mobility Aid suppliers – OttoBock, Jay, Leckey, Mobility Plus etc both in the NT and QLD, 2010 - current*

List education and training sessions you have attended. Include details such as title, type, date. For example:* *Advanced and Half Day Ramp workshop conducted by Liz Ainsworth (21st and 2nd March 2012)*
* *Pressure care in-service by SEAT Clinical Leader including demonstration on use of pressure mapping technology (2011)*
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* *Trade exhibitions and information sessions presented by Mobility Aid suppliers – OttoBock, Jay, Leckey, Mobility Plus etc both in the NT and QLD, 2010 - current*

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| * If applicable, outline teaching, training or mentoring you provide specifically relating to the equipment category/categories you have nominated:

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| * If applicable, list any roles on advisory panels or committees relevant to the equipment category/categories you have nominated:

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| **2c. Referee Details** |
| Please provide contact details of at least two clinical referees. Referees may be contacted to verify clinical experience statement. |
|  | **Name** | **Position Held** | **Contact Number** |
| **1** |       |       |       |
| **2** |       |       |       |
| **3. Applicant Declaration** |
| By placing your signature below you:1. Confirm that the information you have provided above is true and accurate;
2. Agree to be registered as a TEP Approved Prescriber at the level deemed by TEP to be appropriate to your experience and qualifications;
3. Agree to maintain your skills at the level described within the application, and to notify TEP of any change in your capacity to prescribe;
4. Consent to being contacted if further information is required to support your application; and
5. Agree to review and endorse appropriate TEP prescriptions as requested.

Name:      Signed:      Date:       |

**Application Requirements**

Please ensure that the following documentation is provided (as required). Refer to TEP AP-1 Professional Criteria for Approved Prescribers.

Applications will be returned to the applicant if all the requirements of the application form, as listed below, are not completed.

[ ]  Have you completed all required fields?

* The application is to be completed electronically, printed and signed. The original application and accompanying documentation is to be posted to the address below. No emailed versions will be accepted.

[ ]  Have you attached evidence of your Professional Qualification?

* The following Professional Qualification Documentation must be provided with this application:
* Copy of Registration Certificate with the relevant Professional Registration Board; **OR**
* For Speech Pathologists certified copies of:
* proof of qualification (Graduation Certificate); **AND**
* proof of name change, where relevant.

### Send completed applications to:

Territory Equipment Program (TEP)

Approved Prescriber Registration

PO Box 40596

Casuarina NT 0811

Or email to: TopEndIntake.THS@nt.gov.au

**Additional Information**:

**Copy of Registration Certificate** – a photocopy will be accepted as this will be checked with the Relevant Professional Registration Board. Applications must be in the same name as the Registration Certificate.

**Proof of qualification and name change (as relevant)** – photocopies will only be accepted if they have been certified to be a true copy by one of the following: Justice of the Peace, Commissioner for Oaths, Police Officer, Solicitor, Bank Manager, Postal Manager, Pharmacist, Non Commissioned Officer, Warrant Officer or Australian Defence Force Commissioned Officer. It is not recommended that you send original by post.

All copies of accompanying Professional Qualification Documentation will be sighted and destroyed. The completed Application Form for Prescriber Registration will be retained on file.