*Mental Health and Related Services Act 1998*

# Section 22

# Form 58

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| Part A - Applicant Details | | | | | | | | | | | | | | | | |
| I, | |  | | | | | | | | | | | | | | |
|  | | Title | Given name | | | | | | | Family name of applicant | | | | | | |
| of | |  | | | | | | | | | | | | | | |
|  | | Name of Mental Health Service | | | | | | | | | | | | | | |
| apply for appointment as an Authorised Psychiatric Practitioner (APP).  I confirm that I meet the following criteria for appointment as an APP under the *Mental Health and Related Services Act 1998 (please attach copies of any relevant documentation)*:  **Level 1**  I am entitled under a law of a State or Territory of the Commonwealth to practise as a specialist in the medical specialty of psychiatry.  I have qualifications that are recognised by the Royal Australian and New Zealand College of Psychiatrists as entitling me to fellowship of the College.  I am employed by the Commonwealth, a State or Territory of the Commonwealth, or an agency or authority of the Commonwealth, a State or Territory, as a specialist consultant in the medical specialty of psychiatry.  I am employed by the Commonwealth, a State or Territory of the Commonwealth, or an agency or authority of the Commonwealth, a State or Territory of the Commonwealth, as a psychiatrist.  **Level 2**  I am a medical practitioner employed by an approved treatment facility or approved treatment agency;  I am a psychiatric registrar by the Commonwealth, a State or Territory, or an agency or authority of the Commonwealth, a State or Territory.  **AND**  I have successfully completed an approved training and orientation course for my role as an APP *(please attach a copy of the Certificate of Completion)*.  My qualifications are as follows:  *[please include here relevant information demonstrating experience in working in a mental health service, including training and expertise in assessing and treating persons with mental health problems]* | | | | | | | | | | | | | | | | |
| Signature of Applicant | | | | |  | | | | | | | | Date | | | /     / |
| Part B - Endorsement of Person in Charge | | | | | | | | | | | | | | | | |
| I, |  | | | | | | | | | | | | | | | |
|  | Title | | | Given Name | | | | | Family name of Person in Charge of Approved Treatment Facility | | | | | | | |
| being the Person in Charge of the Approved Treatment Facility within:  Top End Mental Health Service  Mental Health Central Australia Health Service  Confirm that the above person meets the criteria for appointment as an APP and request that the person be appointed as an APP who meets the criteria of:  Level 1  Level 2 | | | | | | | | | | | | | | | | |
| Signature of Person in Charge | | | | | | |  | | | | | Date | | /     / | | |
| PART C - Supervision *(To be completed by Person in Charge)* Is the person employed/to be employed as a Consultant Psychiatrist or in a Senior Psychiatric Registrar Position?  No *(please provide details of proposed formal and informal supervision for the person in the table below)*  Yes  Consultant Psychiatrist  Senior Psychiatric Registrar  **Proposed formal and informal supervision of the person** | | | | | | | | | | | | | | | | |
| **Name(s) of Consultant Psychiatrist Supervisor** | | | | | | | | | | | **Detail of Supervision Arrangements** | | | | | |
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| Additional supervision arrangements *(where appropriate)*: | | | | | | | | | | | | | | | | |
| Part D - Proposed Date of Appointment | | | | | | | | | | | | | | | | |
| **Please note:**  Although the applicant may commence employment with the Approved Treatment Facility at any time, they can only commence exercising the powers of an APP under the *Mental Health and Related Services Act* from the date on which the instrument is signed.  Applications for appointment of an APP will be processed within two working days of receipt of a completed and signed form. | | | | | | | | | | | | | | | | |
| Proposed appointment commencement date: | | | | | | | | | | | /     / | | | | | |
| *(For processing information only)* | | | | | | | | | | | Day / Month / Year | | | | | |
| **AND** | | | | | | | | | | | | | | | | |
| This appointment will cease on: | | | | | | | | /     / | | | | | | | | |
|  | | | | | | | | Day / Month / Year | | | | | | | | |
| **AND** | | | | | | | |  | | | | | | | | |
| is a Locum Doctor | | | | | | | |  | | | | | | | | |
| **OR** | | | | | | | | | | | | | | | | |
| The Appointment is permanent | | | | | | | | | | | | | | | | |
| Signature of Person in Charge | | | | | |  | | | | | | Date | | | /     / | |