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| 1. NDIS Participant Details
 |
| Given NameSurname | Click or tap here to enter text.Click or tap here to enter text. | NDIS Participant Number | Click or tap here to enter text. |
| Date of Birth | Click or tap to enter a date. |

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| 1. Guardian Details (If applicable)
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| Is a guardian or other legal decision maker appointed for the participant? | Choose an item. |
| Type | Choose an item. | Name | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. | **Phone Number** | Click or tap here to enter text. |
| Address for correspondence | Click or tap here to enter text. |

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| Declaration |
| I declare that:* I understand that the NT Department of Health can be contacted at restrictive-practices.authorisation-unit@nt.gov.au
* I understand that I have a right to have access to the information contained within this Restrictive Practices - Application for Authorisation form.
* I acknowledge that the information contained within this Restrictive Practices - Application for Authorisation form has been collected for the purpose of making an authorisation decision (determination) in relation to the Application for Authorisation of Restrictive Practices.
* I consent to the Department of Health disclosing the information contained within this this Restrictive Practices - Application for Authorisation form to various persons or bodies, or classes of persons or bodies, including, but not limited to, the NDIS Quality and Safeguards Commission, NT statutory bodies, National Disability Insurance Agency, the NDIS participant and/or family/carers identified in this Restrictive Practices - Application for Authorisation form, internal Department of Health staff, other NT agencies and guardians or substitute decision makers;
* I consent to the Senior Practitioner conducting activity necessary as part of the authorisation process including seeking further information in relation to the authorisation application.
* I consent to the Senior Practitioner using any or all of the information contained within this Restrictive Practices - Application for Authorisation form and any subsequent information which may be obtained to make an authorisation determination.
* I consent to the Senior Practitioner using de-identified information contained within this Restrictive Practices - Application for Authorisation form for research, or the compilation or analysis of statistics.
* I acknowledge that it is an offence to provide false or misleading information to the NT Department of Health under the Bill and under section 43BE of the *Criminal Code Act 1983.*
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| **Signature****NDIS Participant/guardian or other legal decision maker appointed for the participant** |  |
| **Full Name** | Click or tap here to enter text. |
| **Date** | Click or tap to enter a date. |
| Further informationUpload this signed form with your authorisation request: <https://nthealth-sngy7thh.patientsafety.com/portal/#/form/74c6d18c-eef8-4b86-88ca-44fa22282270>  |
| End of form |