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| Before you fill in the form Under the ***National Disability Insurance Scheme (Authorisations) Act 2019*** section 14(2)(iii) an application for an authorisation or interim authorisation must include information that shows the provider has engaged in consultation about the proposed use of a restrictive practice with:   1. The participant; and 2. The participant’s family, carers, guardian/s or other relevant person. | | | |
| Fields marked with caret (^) are office use only. | | | |
| Office use only^ | | | |
| Date received ^ | Click or tap to enter a date. | RPA No ^ | Allocate a number |

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| 1. Application Details | | | |
| Date |  | Request Type | Interim  Authorisation |
| 1. NDIS Participant Details | | | |
| Given Name  Surname | Click or tap here to enter text.  Click or tap here to enter text. | NDIS Participant Number | Click or tap here to enter text. |
| Gender | Choose an item. | Date of Birth | Click or tap to enter a date. |

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| 1. Guardian Details (If applicable) | | | | |
| 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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| 1. Consultation |
| **Provide evidence on how the participant, family and guardian/s were involved in the development of the NDIS behaviour support plan which contains restrictive practices to be used as part of the response strategies for behaviours of concern.** |
| Click or tap here to enter text. |

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| **Signature** |  |
| **Full Name** | Click or tap here to enter text. |
| **Job Title** |  |
| **Service Provider Name** |  |
| **Date** | Click or tap to enter a date. |
| **Witnessed by** | |
| **Signature** |  |
| **Full Name** | Click or tap here to enter text. |
| **Date** | Click or tap to enter a date. |
| **Job Title** | Click or tap here to enter text. |
| **Applicant NDIS Provider Name** | Click or tap here to enter text. |
| Further information Email your completed form with the *Restrictive Practices – Application for Authorisation (RPA-1*) to [restrictive-practices.authorisation-unit@nt.gov.au](mailto:restrictive-practices.authorisation-unit@nt.gov.au) | |
| End of form | |