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| Before you fill in the form Each Implementing Service Provider **must** complete this form detailing any restrictive practices applied to the NDIS participant in the 12 months **prior** to the date of this application. | | | |
| 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. NDIS Service Provider Details (SP) | | | |
| Name | Click or tap here to enter text. | NDIS Provider Number | Click or tap here to enter text. |
| Contact Officer | Click or tap here to enter text. | Position | Click or tap here to enter text. |
| Address | Click or tap here to enter text. | | |
| Email | Click or tap here to enter text. | Phone | Click or tap here to enter text. |

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| 7. Restrictive Practice Details | | | | | |
| **Have restrictive practices been used in the 12 months preceding the date of this application? If yes, provide details below:** | | | | Choose an item. | |
| **Date** | **Restrictive Practice** | **Sub Type** | **Authorised** | | **Comments** |
| Click or tap to enter a date. | Choose an item. | Choose an item. | Choose an item. | | Click or tap here to enter text. |
| Click or tap to enter a date. | Choose an item. | Choose an item. | Choose an item. | | Click or tap here to enter text. |
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| Declaration | |
| I declare that:   * I am duly authorised by the NDIS participant and/or their guardian/s to submit this application for authorisation. * I acknowledge that the Department of Health may share the information contained on this application form with relevant Commonwealth, state and territory agencies, including the police. * To the best of my knowledge, the information provided in this request form is true, correct and accurate. * I acknowledge giving false or misleading information to the Department of Health is a serious offence under section 43BE of the *Criminal Code Act 1983*. | |
| **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. |
| **NDIS Service Provider Details** | 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 | |