Nominee acknowledgement

**Confirmation by nominee *(to be completed by the nominee)***

I, *(insert title and full name of practitioner here)*, consent to being nominated to act as an auditor for *(insert title and full name of nominee here).*

In doing so, I confirm the following:

1. I am (complete the following applicable option/s):

|  |  |
| --- | --- |
|  | a registered health practitioner who holds registration with the *(insert relevant board)* Board of Australia – Ahpra registration number *(insert number here)* |
|  | An unregistered health practitioner who holds accreditation with and/or is a member of *(insert full name of the relevant professional institute/association/accrediting body/other (please specify).* |

1. I have been provided with and have read a copy of the practitioner’s schedule of conditions and/or schedule of restrictions and I am aware of the specific audit conditions/restrictions imposed.
2. I am eligible to act as an auditor as I:
   1. am at least 18 years of age
   2. do not have a close collegiate, family, social, contractual or financial, or treating relationship with the practitioner
   3. have attached a copy of my curriculum vitae to demonstrate I have suitable training, experience and/or qualifications in order to provide the audit required
   4. do not have any current conditions, undertakings or restrictions on my registration and/or right to practise as a result of disciplinary action
   5. have not been the subject of any adverse findings in previous disciplinary proceedings
   6. satisfy any additional criteria outlined in the practitioner’s schedule of conditions and/or schedule of restrictions.
3. If I am approved as an auditor, I agree to provide an audit plan to the Office of the Health Ombudsman (OHO) outlining the form the audit/s will take and how the areas of concern for the Health Ombudsman will be addressed.
4. I am willing to provide reports to the OHO on completion of the audit/s specifically addressing:
   1. the practitioner’s compliance with the schedule of conditions and/or schedule of restrictions
   2. that the audit focussed on the concerns and requirements as outlined in the practitioner’s schedule of conditions and/or schedule of restrictions
   3. my findings and my analysis of the results of the audit
   4. Whether I have, or am aware of any, concerns about the practitioner’s conduct, professional performance and/or fitness to practice
5. I agree to immediately contact the OHO if I have a concern or become aware of a concern about
   1. the practitioner’s compliance with the schedule of conditions and/or schedule of restrictions and/or
   2. the practitioner’s conduct, professional performance and/or fitness to practise.

**Contact details for auditor**

Name:

Place of employment:

Postal address:

Phone number:

Email address:

**Acknowledgement by auditor**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: | [Choose date] |

Please return this form with required attachments to the Office of the Health Ombudsman

Office of the Health Ombudsman

**EMAIL:** [**monitoring@oho.qld.gov.au**](mailto:monitoring@oho.qld.gov.au)

**CALL: 07 3158 1329**

**FAX: 07 3319 6350**

**WRITE: PO Box 13281 George Street  
Brisbane Qld 4003**

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