# Request for approval of employment and practice locations

I, *(insert title and full name of practitioner here)*, am currently subject to conditions on my registration and/or restrictions on my right to practise imposed by the Health Ombudsman, as outlined in my *(tick and complete applicable option/s)*:

schedule of conditions, effective from *(insert date conditions came into effect here)*

schedule of restrictions, effective from *(insert date restrictions came into effect here)*.

I confirm that I am currently *(tick applicable option/s)*:

employed as a health service provider

self-employed as a health service provider

not employed as a health service provider.

In accordance with my schedule of conditions and/or schedule of restrictions, I seek approval to *(choose an option)* employment at the following practice locations:

|  |  |
| --- | --- |
| Practice location 1 | |
| Position: | *(Insert position title and description)* |
| Employment type: | *(Select one)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical location of practice)* |
| Employer or ‘senior person’[[1]](#footnote-1) contact name and position: | *(Insert contact name)* |
| Contact phone number: | *(Insert contact phone number)* |
| Contact email address: | *(Insert contact email address)* |

Signature: Date: *Click here to enter a date.*

|  |  |
| --- | --- |
| Practice location 2 | |
| Position: | *(Insert position title and description)* |
| Employment type: | *(Select one)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical location of practice)* |
| Employer or ‘senior person’[[2]](#footnote-2) contact name and position: | *(Insert contact name)* |
| Contact phone number: | *(Insert contact phone number)* |
| Contact email address: | *(Insert contact email address)* |
| Practice location 3 | |
| Position: | *(Insert position title and description)* |
| Employment type: | *(Select one)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical location of practice)* |
| Employer or ‘senior person’[[3]](#footnote-3) contact name and position: | *(Insert contact name)* |
| Contact phone number: | *(Insert contact phone number)* |
| Contact email address: | *(Insert contact email address)* |

I have provided my employer (or senior person, if the practitioner is the employer) at each practice location above with a copy of my schedule of conditions and/or schedule of restrictions.

Signature: Date: *Click here to enter a date.*

Please return this form to the Office of the Health Ombudsman.

1. For the purposes of this form, a ‘senior person’ is defined as a person at the place of practice where the practitioner is providing a health service (practising) such as the Director of Medical Services, Director of Nursing, Senior Practice Manager, Senior Manager, Senior Partner, Proprietor, Owner, or equivalent. [↑](#footnote-ref-1)
2. For the purposes of this form, a ‘senior person’ is defined as a person at the place of practice where the practitioner is providing a health service (practising) such as the Director of Medical Services, Director of Nursing, Senior Practice Manager, Senior Manager, Senior Partner, Proprietor, Owner, or equivalent. [↑](#footnote-ref-2)
3. For the purposes of this form, a ‘senior person’ is defined as a person at the place of practice where the practitioner is providing a health service (practising) such as the Director of Medical Services, Director of Nursing, Senior Practice Manager, Senior Manager, Senior Partner, Proprietor, Owner, or equivalent. [↑](#footnote-ref-3)