# Practitioner acknowledgement

I, *(insert title and full name of practitioner here)*, am currently subject to conditions imposed on my registration and/or restrictions imposed on my provision of health services 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)*.

By signing this form, I acknowledge and confirm I understand the following conditions/restrictions that are listed in the ‘scope of practice’ as specified in my schedule of conditions/restrictions:

1. Condition/restriction 1.
2. Condition/restriction 2.
3. Condition/restriction 3.
4. …………….
5. …………….

I have received and read the full schedule of conditions and/or restrictions and understand I must comply with all imposed conditions/restrictions and any related protocol/s stated in the conditions/restrictions.

I understand the definitions detailed in the schedule of conditions and/or restrictions.

I understand that failure to comply with any imposed condition/restriction may result in the Health Ombudsman taking further action.

I understand staff of the Office of the Health Ombudsman will actively monitor my compliance with the conditions/restrictions in accordance with authorities provided by me as required by my conditions/restrictions, and legislative provisions of the *Health Ombudsman Act 2013.*

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

Please return this form 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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