## Nomination of practice staff for the booking of appointments *(to be completed by practitioner)*

By signing this form I, *(insert title and full name of practitioner)*, acknowledge and confirm that:

1. the following information is accurate and represents all staff at each practice location who are responsible for the booking of patient appointments.
2. I have advised each nominated practice staff member of the conditions imposed on my registration, specifically that I cannot have contact with *(insert identified patient group stated in conditions)* without the presence of a practice monitor.
3. Each nominated practice staff member is aware the Office of the Health Ombudsman may contact them and exchange information regarding the booking of appointments and the information provided to patients or their legal guardians.

### Nominees’ details

|  |  |
| --- | --- |
| Nominee 1 | |
| Full name | *(Insert full name of nominee)* |
| Position | *(Position held at place of practice)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical address of practice)* |
| Nominee’s phone number: | *(Insert nominee’s contact phone number/s)* |
| Nominee’s email address: | *(Insert nominee’s email address)* |

|  |  |
| --- | --- |
| Nominee 2 | |
| Full name | *(Insert full name of nominee)* |
| Position | *(Position held at place of practice)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical address of practice)* |
| Nominee’s phone number: | *(Insert nominee’s contact phone number/s)* |
| Nominee’s email address: | *(Insert nominee’s email address)* |

Practitioner’s signature: Date: *Click here to enter a date.*

### Nominees’ details (continued)

|  |  |
| --- | --- |
| Nominee 3 | |
| Full name | *(Insert full name of nominee)* |
| Position | *(Position held at place of practice)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical address of practice)* |
| Nominee’s phone number: | *(Insert nominee’s contact phone number/s)* |
| Nominee’s email address: | *(Insert nominee’s email address)* |

|  |  |
| --- | --- |
| Nominee 4 | |
| Full name | *(Insert full name of nominee)* |
| Position | *(Position held at place of practice)* |
| Practice name: | *(Insert company/business/trading name)* |
| Practice location: | *(Insert physical address of practice)* |
| Nominee’s phone number: | *(Insert nominee’s contact phone number/s)* |
| Nominee’s email address: | *(Insert nominee’s email address)* |

Practitioner’s 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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