# Nomination for approval *(to be completed by the practitioner)*

I, *(insert title and full name of practitioner here)*, nominate *(insert title and full name of nominee here)* to be approved to act as a supervisor as required under my *(tick and complete applicable option/s)*:

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

I confirm that the nominee meets the Health Ombudsman’s criteria to act as a supervisor as specified in the Office of the Health Ombudsman (OHO) *Information for supervisors* fact sheet and my schedule of conditions/schedule of restrictions.

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

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

I, , consent to this nomination to act as a supervisor   
for .

In doing so, I confirm that:

1. I am (complete applicable option/s)  
     
    a registered health practitioner who holds registration with the 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])*.
2. I am eligible to act as a supervisor 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 suitable training, experience and/or qualifications in order to provide the supervision required
   4. do not have any current conditions, undertakings or restrictions on my registration and/or my right to practise as a result of disciplinary action
   5. have not have 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. I have been provided with and read a copy of the *Information for supervisors* fact sheet.
4. I have been provided with and read a copy of the practitioner’s schedule of conditions and/or schedule of restrictions and I am aware of the specific supervisor conditions/restrictions imposed.
5. I am willing and able to act as a supervisor for the practitioner and provide the requisite level of supervision to the practitioner as required in the schedule of conditions and/or schedule of restrictions.
6. I attach a copy of my current curriculum vitae and a certified copy of my driver’s license, passport or other valid photographic identification that includes a sample of my signature.
7. I am willing to be contacted by the OHO as necessary for the purposes of monitoring the practitioner’s compliance with the schedule of conditions and/or schedule of restrictions.
8. I am willing to provide reports to the OHO on request specifically addressing
   1. the practitioner’s compliance with the schedule of conditions and/or schedule of restrictions
   2. that the supervision occurred at a level required by the practitioner’s schedule of conditions and/or schedule of restrictions
   3. any period of absence or any period of time where I was not otherwise able to provide supervision
   4. whether I have or am aware of any concerns about the practitioner’s conduct, professional performance and/or fitness to practise.
9. 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
   2. the practitioner’s conduct or professional performance.

## Contact details for supervisor

Supervisor’s title, name and position:

Place of employment where supervision to be provided:

Supervisor’s postal address:

Supervisor’s phone number:

Supervisor’s email address:

Signature: Date:

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