Pharmacy Board Ahpra

Application for approval of supervised practice

Profession: **Pharmacy**

Part 7 Division 6 of the Health Practitioner Regulation National Law (the National Law)

This form is to be used to apply for a Pharmacy Board of Australia (the Board) approved period of supervised practice in order to be eligible for general registration without conditions.

Applicants **must** have current provisional registration, limited registration or general registration with conditions in order to undertake supervised practice.

All applicants are required to lodge an application for approval of supervised practice in accordance with the following:

1. This form must be lodged and approved by the Board before any supervised practice is undertaken.
2. New graduates of a *Board Approved program of study* **must** provide this application for approval of supervised practice form as part of their online application for provisional registration at **www.pharmacyboard.gov.au/Registration/Forms**
3. You are required to provide a current email address on this application form. Notification of approval of this application will be sent via email.
4. Where more than one provisionally registered pharmacists are to undertake supervised practice at the one premises, the preceptor may copy Parts B and C of this form and attach them to each applicant's copy of Part A of this form.

Incomplete applications will be returned to the applicant which may delay commencement of supervised practice.

It is important that you refer to the Board's registration standards, codes and guidelines and the *Intern pharmacist and preceptor guide* when completing this form. Registration standards, codes and guidelines and the *Intern pharmacist and preceptor guide* can be found at **www.pharmacyboard.gov.au**

This application will not be considered unless it is complete and all supporting documentation has been provided. Supporting documentation **must** be certified in accordance with the Australian Health Practitioner Regulation Agency (Ahpra) guidelines. For more information, see *Certifying documents* in the *Information and definitions* section of this form.

Privacy and confidentiality

The Board and Ahpra are committed to protecting your personal information in accordance with the *Privacy Act 1988* (Cth). The ways the Board and Ahpra may collect, use and disclose your information are set out in the collection statement relevant to this application, available at **www.ahpra.gov.au/privacy**.

By signing this form, you confirm that you have read the collection statement. Ahpra's privacy policy explains how you may access and seek correction of your personal information held by Ahpra and the Board, how to complain to Ahpra about a breach of your privacy and how your complaint will be dealt with. This policy can be accessed at **www.ahpra.gov.au/privacy**.

Symbols in this form

Additional information
Provides specific information about a question or section of the form.

Attention
Highlights important information about the form.

Attach document(s) to this form
Processing cannot occur until all required documents are received.

Signature required
Requests appropriate parties to sign the form where indicated.

Completing this form

- Read and **complete all questions**.
- Ensure that **all pages** and required **attachments** are returned to Ahpra.
- Use a **black** or **blue** pen only.
- Print clearly in BLOCK LETTERS
- Place X in **all** applicable boxes: ☒
- **DO NOT send original documents.**

Do not use staples or glue, or affix sticky notes to your application. Please ensure all supporting documents are on A4 size paper.

PART A – To be completed by the applicant

SECTION A: Personal details

The information items in this section of the application marked with an asterisk (*) will appear on the public register.

1. What is your name?

Title* MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ☐ SPECIFY

Family name*

First given name*

Middle name(s)*

Previous names known by (e.g. maiden name)

If you have ever been formally known by another name, or you are providing documents in another name, you **must** attach proof of your name change unless this has been previously provided to the Board. For more information, see *Change of name* in the *Information and definitions* section of this form.

2. What are your birth details?

Date of birth

D D / M M / Y Y Y Y

Country of birth

3. Do you currently hold limited registration, provisional registration, or general registration (with conditions) with the Board?

YES ☒

Please provide your registration number below

Registration number*

P H A

NO ☒

If you did not complete your application online, you **must** attach your application for limited, provisional or general registration.

4. What is your reason for submitting this application?

Mark only one box

- ☒ This is my first application for supervised practice
- ☒ To add a rotation site to my approved supervised practice site
- ☒ To change my supervised practice site
- ☒ To change my preceptor

SECTION B: Contact information

Once registered, you can change your contact information at any time.
Please go to **www.ahpra.gov.au/login** to change your contact details using your online account.

5. What are your contact details?

Provide your current contact details below – place an ☒ next to your preferred contact phone number.

Business hours ☒

Mobile ☒

After hours ☒

Email

6. What is your residential address?

Residential address **cannot** be a PO Box.

Site/building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State or territory (e.g. VIC, ACT)**/International province***

Postcode/ZIP*

Country (if other than Australia)

7. What is your principle place of practice?

Principal place of practice for a registered health practitioner is:

- the address at which you will predominantly practise the profession; or
- your principal place of residence, if you are not practising the profession or are not practising the profession predominantly at one address.

Principal place of practice **cannot** be a PO Box.

The information items marked with an asterisk (*) will appear on the public register.

Site name

Site/building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT)

Postcode*

8. What is your mailing address?

Your mailing address is used for postal correspondence

☒ My residential address

☐ Other ***(Provide your mailing address below)***

Site/building and/or position/department (if applicable)

Address/PO Box (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

State or territory (e.g. VIC, ACT)**/International province**

Postcode/ZIP

Country (if other than Australia)

SECTION C: Supervised practice

9. Why are you undertaking supervised practice?

Supervised practice cannot commence until this application has been approved by the Board.

For graduates of Australian approved programs of study, supervised practice cannot commence until official notification of course completion has been received from the relevant institution, and the application for provisional registration has been approved by the Board.

See **www.pharmacyboard.gov.au/Registration/Forms**

Choose appropriate option

☒ I have current general registration with conditions (or equivalent) and will undertake supervised practice as part of the Board's requirements for persons seeking to return to practice.

☒ I currently hold or have applied for provisional registration, and have successfully completed or am in the process of completing a course in pharmacy practice approved by the Board.

Name of institution (University/College/Examining body)

Title of qualification (e.g. BPharm)

☒ I am an overseas qualified pharmacist and am required to complete a period of supervised practice.

Name of institution (University/College/Examining body)

Title of qualification (e.g. BPharm)

☒ Other ***(Provide details below)***

Attach a separate sheet if all your reasons for undertaking supervised practice does not fit in the space provided.

10. How many hours of supervised practice are you seeking approval for?

Hours

SPECIFY

11. What is the proposed commencement date of supervised practice under this application?

Supervised practice **must not** commence prior to approval of this application and your application for limited, provisional or general registration.

Commencement date

D D / M M / Y Y Y Y

12. Please list any other periods of supervised practice undertaken prior to the period covered by this application.

Additional supervised practice

Hours completed: SPECIFY

Completion date: D D / M M / Y Y Y Y

Additional supervised practice

Hours completed: SPECIFY

Completion date: D D / M M / Y Y Y Y

Additional supervised practice

Hours completed: SPECIFY

Completion date: D D / M M / Y Y Y Y

SECTION D: Applicant's declaration

Supervised practice can only commence once this application has been approved. The applicant and preceptor will receive email notification from Ahpra of receipt of this application, and the outcome of this application.

I declare that the information contained in this application about me is true and correct.

I confirm that I am authorised to provide the personal details contained in this form.

I consent to my personal details and information being checked by a third party system to verify and confirm my identity.

Provisional and limited registrants undertaking supervised practice

I confirm that the supervised practice arrangements proposed in this application **will not commence** until I have confirmed on the public register that the supervised practice details have been recorded in the *Registration Requirements* field on my registration record.

General registrants with conditions

I confirm that the supervised practice arrangements proposed in this application **will not commence** until I receive notification from Ahpra that my application has been approved.

Name of applicant

Signature of applicant

SIGN HERE

Date

D D / M M / Y Y Y Y

PART B – To be completed by the pharmacist in charge or director of pharmacy

SECTION E: Premises details

13. What are the name and address details of your premises?

Site name

Site/building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT)

Postcode*

You **must** attach a separate sheet with details of any additional premises which are to be included in the training program.

14. What are the contact details for your premises?

Business hours

Mobile

Facsimile

Email

15. What is your premises type?

As outlined in the Board's *Supervised practice arrangements* registration standard, at least 50 per cent of the required supervised practice hours must be undertaken in a community pharmacy or a hospital pharmacy department, unless otherwise approved by the Board.

Mark only one box

- ☐ Community pharmacy – ***Go to the next question***
- ☐ Hospital pharmacy department – ***Go to question 19***
- ☐ Other – ***Go question 17***

16. Does the community pharmacy have approval to supply pharmaceutical benefits under section 90 of the National Health Act 1953?

YES ☐ ***Go to question 19*** NO ☐ ***Go to question 18***

17. What is your premises type if it is not a premises outlined in question 15?

Other premises type may be approved by the Board if it provides a broad exposure to pharmacy practice and enables you to address the competency standards relevant to entry-level practice.

Mark only one box

- ☐ Pharmaceutical industry
- ☐ Compounding facility
- ☐ Other ***(please specify)***

18. What are the range of pharmacy services provided at these premises?

To make sure you are suitably prepared to practise in any practice setting once you gain general registration, you should outline how the premises will contribute to providing exposure to a broad range of services during the completion of the supervised practise period required for general registration.

Mark all options applicable

- ☐ Dispensing (non-PBS medicines only)
- ☐ Clinical pharmacy
- ☐ Medicines information
- ☐ Counselling patients
- ☐ Provision of non-prescription medicines
- ☐ Services to residential care facilities
- ☐ Vaccination service
- ☐ Filling of dose administration containers
- ☐ Opioid substitution therapy
- ☐ Services to private hospitals
- ☐ Educational talks to community groups
- ☐ Outpatients
- ☐ Diagnostic testing (e.g. blood glucose monitoring)
- ☐ Screening and risk assessment
- ☐ Medication review services (e.g. MedsCheck, HMR's)
- ☐ Drug information services
- ☐ Compounding of medicines
- ☐ Non-sterile manufacturing
- ☐ Sterile manufacturing
- ☐ Cytotoxic manufacturing
- ☐ Other ***(please specify below)***

SPECIFY

You **must** attach a separate sheet detailing a proposal how the premises will provide good practice experience and exposure to a range of activities, and include a training plan as detailed in the *Intern pharmacist and preceptor guide*.

19. What is the minimum number of pharmacists holding general registration that will be working at the premises any time when interns are present?

Minimum number of pharmacists who hold general registration at the premises

SPECIFY

20. What is the maximum number of interns (provisionally registered pharmacists) that will be working at the premises, including the intern on this application?

Supervised practice hours may only be undertaken in premises where the total number of provisionally registered pharmacists does not exceed the total number of supervising pharmacists at any time.

Number of interns at premises

SPECIFY

21. Who is the proprietor(s) of the premises?

Proprietor

MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ☐ SPECIFY

Family name

First given name

Middle name(s)

Additional proprietor

MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ☐ SPECIFY

Family name

First given name

Middle name(s)

You **must** attach a separate sheet if all your proprietor information does not fit within the space provided.

22. What is the name of the pharmacist in charge or director of pharmacy?

Title*

MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ☐ SPECIFY

Family name*

First given name*

Middle name(s)*

Previous names known by (e.g. maiden name)

Certification of compliance for hospital pharmacy departments and community pharmacies

I certify that these premises comply with the approval requirements of the pharmacy approval authority in this jurisdiction.

Name of pharmacist in charge or director of pharmacy

Date

D D / M M / Y Y Y Y

Signature of pharmacist in charge or director of pharmacy

SIGN HERE

PART C – To be completed by the preceptor

SECTION F: Preceptor details

Eligibility criteria for preceptors

A pharmacist may be approved as a preceptor if he or she have been registered and have practised for at least 12 months prior to the commencement of the period of supervised practice covered by this application. To be eligible to proceed with this application as the nominated preceptor, you must answer YES to question 25 or outline your reasons in writing to the Board on why the criteria should not be applied in this case. Preceptors should be aware of their ongoing continuing professional development obligations under the Board's *Registration standard: Continuing professional development*. For more information, see *Continuing professional development* in the *Information and definitions* section of this form.

For further information, refer to the *Registration standard: Supervised practice arrangements* which can be found at **www.pharmacyboard.gov.au/Registration-Standards.**

Supervision of interns

An approved preceptor is required to supervise the training of a provisionally registered intern or other person undertaking supervised practice, or delegate day-to-day supervision to a suitably qualified pharmacist at the approved site. A preceptor should be present at the training premises on a regular basis. Pharmacists who do not regularly practise at the training site are advised not to apply for approval as a preceptor as this role is considered best undertaken by pharmacists who can meet the on-site training requirements of supervised practice and preceptor requirements.

Supervised practice across multiple training sites

If supervised practice is undertaken concurrently across multiple training sites (as specified in *Section D: Premises details*), the approved preceptor is responsible for coordinating training across these sites.

23. What are your details?

Title*

MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ☐ SPECIFY

Family name*

First given name*

Middle name(s)*

Previous names known by (e.g. maiden name)

Date of birth D D / M M / Y Y Y Y

Ahpra registration number P H A

Email

24. What is your year of initial general registration as a pharmacist?

Year SPECIFY

25. Will you, on the proposed date of commencement of supervised practice detailed on this application, have held general registration as a pharmacist and will have practised as a pharmacist for at least 12 months?

YES ☐ NO ☐

You **must** attach a separate sheet with your reasons for why this criteria should not be applied.

26. Have you acted as a preceptor for the purpose of conducting supervised practice (internship) before?

YES ☐ NO ☐

27. Have you accessed the *Preceptor guide* and are you aware of your responsibilities as a preceptor?

YES ☐ NO ☐

The Board's *Intern pharmacist and preceptor guide* outlines the Board's expectations of preceptors conducting supervised practice, including their responsibilities and how they should prepare adequately for their role.

The guide includes sample training programs to assist preceptors in developing an on-site training program to be conducted throughout the period of supervised practice and advice regarding the conduct of formal discussion time during training.

The guide is published on the Board's website at **www.pharmacyboard.gov.au/Registration/Internships**

28. How many hours each week do you have contact with the intern?

For more information, see *Supervision of interns* at the start of *Section E: Preceptor details* in this form.

Hours of contact a week

SPECIFY

SECTION G: Preceptor's declaration

The preceptor **must** sign below. All correspondence to preceptors will be sent to the training site address if an email address has not been provided. The applicant and preceptor will receive email notification from Ahpra of receipt of this application, and the outcome of this application.

I declare that the information contained in this application about me is true and correct.

Provisional and limited registrants undertaking supervised practice

I confirm that the applicant's supervised practice arrangements proposed in this application **will not commence** until I have confirmed on the public register that the supervised practice details have been recorded in the *Registration Requirements* field on the applicant's registration record.

General registrants with conditions

I confirm that the applicant's supervised practice arrangements proposed in this application **will not commence** until I receive notification from Ahpra that the application has been approved.

Name of preceptor

Signature of preceptor

SIGN HERE

Date

D D / M M / Y Y Y Y

SECTION H: Checklist

Have the following items been attached or arranged, if required?

Additional documentation		Attached
Question 1	Evidence of a change of name	☐
Question 3	Your application for limited, provisional or general registration	☐
Question 9	A separate sheet with additional reasons for undertaking supervised practice	☐
Question 13	A separate sheet with details of any additional premises which are to be included in the training program	☐
Question 18	A separate sheet proposing how the premises will provide good practice experience and exposure to a range of activities	☐
Question 21	A separate sheet with any additional proprietor information	☐
Question 25	A separate sheet with reasons why eligibility criteria should not be applied	☐

Do not email this form.

Please submit this completed form and supporting evidence using the Online Upload Service at **www.ahpra.gov.au/registration/online-upload**.
You may contact Ahpra on 1300 419 495

Information and definitions

CERTIFYING DOCUMENTS

DO NOT send original documents.

Copies of documents provided in support of an application, or other purpose required by the National Law, must be certified as true copies of the original documents. Each and every certified document **must**:

- be in English. If original documents are not in English, you must provide a certified copy of the original document and translation in accordance with Ahpra guidelines, which are available at **www.ahpra.gov.au/registration/registration-process**
- be initialled on every page by the authorised officer. For a list of people authorised to certify documents, visit **www.ahpra.gov.au/certify.aspx**
- be annotated on the last page as appropriate e.g. 'I have sighted the original document and certify this to be a true copy of the original' and signed by the authorised officer,
- for documents containing a photograph, the following certification statement must be included by the authorised officer, 'I certify that this is a true copy of the original and the photograph is a true likeness of the person presenting the document as sighted by me', along with their signature, and
- list the name, date of certification, and contact phone number, and position number (if relevant) and have the stamp or seal of the authorised officer (if relevant) applied.

Certified copies will only be accepted via the Online Upload Service at **www.ahpra.gov.au/registration/online-upload**. Photocopies of previously certified documents will not be accepted. For more information, Ahpra's guidelines for certifying documents can be found online at **www.ahpra.gov.au/certify.aspx**

CHANGE OF NAME

You must provide evidence of a change of name if you have ever been formally known by another name(s) or any of the documentation you are providing in support of your application is in another name(s).

Evidence must be a certified copy of one of the following documents:

- Standard marriage certificate (ceremonial certificates will not be accepted)
- Deed poll
- Change of name certificate.

Faxed, scanned or emailed copies of certified documents will not be accepted.

CONTINUING PROFESSIONAL DEVELOPMENT

A registered pharmacist must undertake the continuing professional development (CPD) required by the Board's *Registration standard: Continuing professional development*. Failure to do so may constitute behaviour for which health, conduct or performance action may be taken.

Registered pharmacists are required to complete 40 CPD credits for the 12 month period ending 30 September.

For more information, view the full registration standard online at **www.pharmacyboard.gov.au/Registration-Standards**