

**Stage 2**

**Application Form for Period of Supervised Practice**

**for Internationally-qualified Practitioners**

Please refer to the “Stage 2 Policy and Procedure” when completing this form.

Completed applications may be forwarded to the OTC as follows:

**Email**: in pdf format scanned as one document

admin@otcouncil.com.au

If you choose to forward your application via the mail, please ensure it is single sided and please do not staple.

PO Box 959

South Perth WA 6951

**Section A: Personal Details**

|  |  |
| --- | --- |
| Family name |  |
| Given name(s) |  |
| Any previous names (eg. prior to marriage) |  |
| Gender | Male ⬜ Female ⬜ |
| Date of birth | Day Month Year |
| Ahpra Registration No. |  |
| Address for correspondence |  |
|  |
|  |
| Contact details – please write clearly | Email  |
| Mobile |
| Date of OTC Stage 1 Assessment Letter |  |
| Qualifications |  | Date of Award |  |
| Awarding Institution  |  | Country |  |
| Current CV including brief summary of experience to date attached ⬜  |

**Section B: Employer’s Details**

|  |  |
| --- | --- |
| Name of employing agency |  |
| Address of employing agency |  |
|  |
|  |
| Position for supervised practice  |  |
| Commencement date of supervised practice  | Day Month Year |
| Hours of work per week for period of supervised practice  |  |
| Please attach a copy of the Position Description for your role ⬜ |

**Section C: Details of Supervision Process**

If two supervisors have been nominated and approved for the period of supervised practice, the supervisors must confer regarding the practitioner’s progress prior to the completion of any assessment report. It is not appropriate for the practitioner to provide communication between two supervisors.

|  |  |
| --- | --- |
| Primary occupational therapist supervisor | Name |
| Position |
| Place of work |
| Contact details:Tel: ………………………………………………Email: Email:  |
| Ahpra Registration no. |
| Qualification (name, institution and conferral date):  |
| Secondary occupational therapist supervisor (if required) | Name |
| Position |
| Place of work |
| Contact details:Tel: ………………………………………………Email:  |
| Ahpra Registration no. |
| Qualification (name, institution and conferral date):  |
| **Please include curriculum vitae for each supervisor.** **If a third supervisor is required, please attach as a separate document, including all information above.** |

Is the supervisor on-site? Yes No

If no, please outline how the supervision requirements below will be undertaken. Please add additional rows as needed:

|  |  |
| --- | --- |
| Details of formal supervision with occupational therapy supervisor | **As a minimum** weekly face-to-face supervision (one hour per week) for the first six weeks to include four sessions of direct practice observation by the supervisor during the assessment and treatment of clients.Weekly supervision – one hour per week for the first six weeks ⬜Four sessions of direct observation by the supervisorduring the first six weeks. ⬜ After six weeks, supervision may reduce to one houra fortnight. ⬜ Two additional sessions of direct practice observation to be undertaken after the first six weeks and prior to submission of midway progressreport ⬜ |
| Types of supervision:Ideally supervision should be face-to-face however supervision via telephone or Skype/Zoom or similar is acceptable.Direct practice observation, unless in a remote location, means the supervisor needs to be present during the assessment and clinical interventions. If in a remote location, direct practice observation may be undertaken in real time or recorded with playback options via Skype/Zoom or similar. Relevant dates – recording and review – need to be shown on the supervision log. |
| **Record all supervision, and type of supervision, on the OTC Supervision Log (template is available in the “forms” section of the website) and submit the supervision log with the midway progress and final reports.**  |
| **SECTION D – Practice Context - Please circle as appropriate****Please identify area of practice**: Paediatrics Mental Health Aged careWork rehabilitation Academia Hand and upper limbGeneral medical RehabilitationOther (please specify) ………………………....**Please indicate location of period of supervised practice**: Metropolitan Rural**Please indicate nature of organisation**: Sole practitioner private practice Small private practicePrivate company/hospital in single location Private company with multiple locationsPublic health service/hospital NGOUniversity or teaching institution |
| We, the supervisor and the supervisee, have discussed and collaborated on the development of the attached Supervised Practice Plan.We, the supervisor and the supervisee, agree to comply with the requirements of the OTC which may be imposed during the period of supervised practice in relation to the provision and/or revision of reports. |
| Signature of practitioner |  | Date |
| Signature of supervisor |  | Date |

**Please use the “Guidelines for Completion of the Supervised Practice Plan” to assist with the development of your Supervised Practice Plan**

**Checklist**

Please ensure the following **documents are attached** to this Application Form

⬜ Practitioner’s curriculum vitae

⬜ Practitioner’s job description

⬜ Supervisor’s curriculum vitae. If more than one supervisor, please provide curriculum vitae for each one.

⬜ Supervised Practice Plan signed by you and your supervisor.

# Fees

The fee must accompany this application form and made payable to OTC in Australian dollars by one of the following methods:

* A money order issued by Australia Post made payable to the Occupational Therapy Council.
* Credit card – form available on the website and should accompany this application.
* A bank cheque drawn by an Australian bank made payable to the Occupational Therapy Council.
* Direct debit as follows:

Account name: Occupational Therapy Council

Bank: Westpac

BSB: 036 308

Account no.: 28 2504

International Swift: WPACAU2S

Please ensure your name appears on the statement of the OTC, and you advise us via email when payment has been made.

**Please do not send your payment of fees in cash by post.**

A receipt will be issued to acknowledge OTC has received your application and fee. The fee is not refundable.

**Section D: Statement of Privacy**

**STATEMENT ON PRIVACY**

**Migration and Registration**

The Occupational Therapy Council of Australia Ltd (OTC) is required to observe the provisions of the Commonwealth Privacy Amendment (Private Sector) Act 2000, effective from 21 December 2001. It sets out the requirements for the collection and use of personal information collected before and after that date.

As from 21 December 2001 each of the Application Forms used by the OTC is required to include a statement relating to the OTC’s privacy procedures. Each must be signed by the applicant to give formal consent for the OTC to collect and hold personal information.

**If you have any concerns regarding this statement, please contact the OTC via email at admin@otcouncil.com.au**

**If consent is not provided, the OTC will not be able to process your application.**

**You must sign one of these consent forms for every application form that you are submitting to the OTC.**

*Your privacy is respected by the OTC. Information collected by the OTC may be used for administering the assessment process and provided to OTC, members of the Australian Health Practitioner Regulation Agency (Ahpra), The Occupational Therapy Board of Australia (OBTA), and approved supervisors.*

*Consent to Collect Information:*

***Full name: ………………………………………………………….***

***Signature: Date:***