



Application to amend annual practising certificate Provisional vocational scope

COS2 – June2005
Registration No.

IMPORTANT INSTRUCTIONS

- This form must be forwarded to the Medical Council office **at least three weeks before** the supervision arrangement or employment changes.
- The following documentation must be included with your application:
 - completed supervision report form
 - copy of letter of appointment
- Doctors working under assessment of the Branch Advisory Body (BAB) must have sections 1, 2 and 3 completed, and forward the form to the BAB to complete section 4.

SECTION 1 – TO BE COMPLETED BY APPLICANT

Forename(s)				Surname:		
Address for medical register:						
I understand that:						
<ul style="list-style-type: none"> • The Medical Council may review my registration at any time. • My clinical supervisor will report to the Medical Council. 						
Signed:				Date:	day / month / year	

SECTION 2 – TO BE COMPLETED BY SUPERVISOR

Forename(s)				Surname:		
Registration number:		Current APC:	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Position:		
I am registered within a vocational scope:		<input type="checkbox"/> Yes / <input type="checkbox"/> No	Scope:			
<ul style="list-style-type: none"> • I have read the Council's document <i>Induction and supervision for newly registered doctors</i> and understand what is required of me. • I agree to supervise the applicant and to forward completed reports at three monthly intervals, or as requested by the Medical Council. 						
Signed:				Date:	day / month / year	

SECTION 3 – TO BE COMPLETED BY EMPLOYER

Position appointed to:				Scope of practice:		
Hospital / Institution / Employer						
Position:	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	Hours per week			
Start date of employment:	day / month / year	End date of employment:	day / month / year			
Name of person signing:				Position:		
Signed:				Date:	day / month / year	

SECTION 4 – TO BE COMPLETED BY THE CHIEF MEDICAL OFFICER (CMO) OR PRACTICE PRINCIPAL

In the DHB environment, the signature of the CMO/CMA or their delegate. In the primary care environment, the signature of the practice manager/practice principal or their delegate.

I agree to the proposed supervision and induction plan and accept responsibility for ensuring the plan attached is implemented.

Name of person signing:		Position:	
Signed:		Date:	day / month / year

SECTION 5 – TO BE COMPLETED BY BRANCH ADVISORY BODY

• The applicant has been advised of and agreed to the assessment procedure. The position and supervisory arrangements are suitable for assessment purposes.

Branch advisory body name:			
Signed:		Date:	
Name:		Position:	

SECTION 6 – FEES (TO BE COMPLETED IF THE APPLICANT IS CHANGING EMPLOYER)

Fee payable NZ \$125.00

Cheque enclosed

Credit card option

Visa *Mastercard*

Card Number Expiry date /

Name on card

Cardholder's signature Date