

**RECERTIFICATION AUDIT 2024**

SUPERVISOR/EMPLOYER DECLARATION

To be completed by your supervisor, or a senior practitioner who holds a current practising certificate issued by the Medical Sciences Council.

Name of Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner’s Registration Number: 30-\_\_\_\_\_\_\_\_\_

Please circle your answers

|  |  |  |
| --- | --- | --- |
| The practitioner has received a satisfactory performance appraisal that demonstrates competence within the last 12 months in the stated scope of practice.  | Yes  | No  |
| I am satisfied that the practitioner complies with the Code of Ethical Conduct.  | Yes  | No  |
| I am satisfied that the practitioner is physically and mentally fit and competent to practise.  | Yes  | No  |

Supervisor/Employer Name:

Position:

|  |  |
| --- | --- |
| Registered as Health Practitioner with:  |   |
| Registration Number:  |  |
| Scope of Practice:  |   |

Supervisor/Employer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_