

**BOARD QUESTIONNAIRE/PRACTITIONER/EMPLOYER DECLARATION
COMPETENCE AUDIT 20__**

Name of Practitioner _____

Registration Number _____

Scope of Practice _____

Please note: A separate form must be completed for each scope of practice in which you hold a current annual practising certificate (APC)

Clinical Hours Required: To maintain your APC the Board has set requirements for clinical hours that must be completed within 3 years prior to the date of application for your APC:

Practise in a single scope: 800 hours minimum with at least 360 of these for patient contact

Practise in more than one scope: At least 360 hours must be for patient contact and an additional 440 hours clinical hours in any scope of practise (see website for more details)

SECTION A: PRACTITIONER TO COMPLETE

Please circle your answers

- I have completed 800 clinical hours in the past three years in **this** scope of practice: **YES/NO**
- I have received a satisfactory performance review which confirms I am clinically competent to practise in **this** scope of practice: **YES/NO**
- I am currently enrolled in and have been actively participating in an MRTB-approved CPD programme in the past twelve months. **YES/NO**
- I am enrolled in the following CPD programme:

Training Scope of Practise Only:

- I have enclosed evidence that I am currently enrolled in a Board-approved CPD programme **YES/NO**

If you are currently being audited/been audited by your Board- approved CPD programme provider within the last 6 months:

- I have enclosed evidence that I am currently being audited, or have been audited by my CPD provider in the previous six months; and **YES/NO**
- I enclose evidence that my CPD activities over the past 3 years relate to the scope of practise that this form pertains to **YES/NO**
- I comply with the Code of Ethics **YES/NO**
- I believe I am physically and mentally competent to practice **YES/NO**

Signature of practitioner: _____

Date: _____

SECTION B: TO BE COMPLETED BY A REGISTERED MEDICAL RADIATION TECHNOLOGIST (e.g. Line Manager) OR A RADIOLOGIST

Please circle your answers

- The practitioner has completed the required clinical hours in the stated scope of practice. **YES/NO**
- 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 the practitioner complies with the Code of Ethics **YES/NO**
- I am satisfied the practitioner is physically and mentally fit, and competent to practise **YES/NO**

Name: _____

Position: _____

Date: _____

Signature: _____