

PART A

**PRACTITIONER DECLARATION
RECERTIFICATION AUDIT 2020**

Name of Practitioner: _____

Registration Number: 40-0 _____

Scope(s) of Practice: _____

CPD Programme Enrolled in: _____
(if applicable)

Complete a separate form for EACH scope of practice in which you hold a current Annual Practising Certificate (APC).

Part A and B must be completed, scanned and emailed along with the documents listed below to mrtbaudit@medsci.co.nz by **Monday 5 August 2020**.

PRACTITIONER DECLARATION

Please circle your answers

| | | |
|---|-----|----|
| I have completed 800 clinical hours in the past three years including 360 hours of patient contact in each scope of practice I hold an Annual Practising Certificate (APC). | Yes | No |
| I have received a satisfactory performance review which confirms that I am clinically competent to practise in each scope of practice I hold an APC. | Yes | No |
| I comply with the Code of Ethics. | Yes | No |
| I believe I am physically and mentally competent to practice. | Yes | No |
| I have provided the Board with the following documents: | | |
| <ul style="list-style-type: none"> • A logbook detailing the CPD activities I have completed in the 36 months up to 31 March 2020 | Yes | No |
| <ul style="list-style-type: none"> • Ten documents as evidence of the completion of the CDP activity including one from each of the three years cover by the audit and six of these evidential documents related to substantive CPD activities | Yes | No |
| <ul style="list-style-type: none"> • Six reflective statements. <ul style="list-style-type: none"> ○ Two related to ethical practice. ○ Two related to my scope of practice. ○ One related to culturally appropriate practice. ○ One other reflective statement | | |
| <ul style="list-style-type: none"> • My employment history for the three years up to 31 March 2020, including a brief description of the duties for each position I have held. | Yes | No |

Signature: _____ Date: _____

Please label all documents with your name and registration number.

PART B

SUPERVISOR/EMPLOYER DECLARATION

RECERTIFICATION AUDIT 2020

To be completed by a registered medical imaging technologist, radiation therapist, nuclear medicine technologist, magnetic resonance imaging technologist, sonographer (e.g. line manager) or a radiologist.

Name of Practitioner: _____

Registration Number: 40-0_____

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 that the practitioner complies with the Code of Ethics. | Yes | No |
| I am satisfied that the practitioner is physically and mentally fit and competent to practise. | Yes | No |

Name: _____

Position: _____

Registered as Health Practitioner with: _____

Registration Number: _____

Scope of Practice: _____

Signature: _____

Date: _____