**RECERTIFICATION AUDIT 2023**

Must be completed and emailed to mrtbaudit@medsci.co.nz by 11 August 2023

|  |  |
| --- | --- |
| Name: |  |
| Registration number: |  |
| Scope of practice: |  |
| CPD programme (if applicable): |  |
| Period being audited: |  |
| Employment history during audit period: |
|  |
| Total months worked during audit period: |  |

PRACTITIONER DECLARATION

Please circle your answers

|  |  |  |
| --- | --- | --- |
| I have completed 290 clinical hours (approx.) in the past 12 months including 120 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:** |
| * A logbook detailing the CPD activities I have completed in the 12 months up to 31 December 2022.
 | Yes  | No  |
| * Three documents as evidence of the completion of the CPD activity. Two of these evidential documents must be related to substantive CPD activities.
 | Yes  | No  |
| * Two reflective statements. One related to substantive practice. The other related to ethical **or** culturally appropriate practice.
 | Yes | No  |
| * My employment history for the 12 months up to 31 December 2022, including a brief description of the duties for each position I have held.
 | Yes  | No  |

Signature: Date:

SUPERVISOR/EMPLOYER DECLARATION

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.

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| --- |
| Supervisor/Employer: |
| Name: |  |
| Position: |  |
| Registered as Health Practitioner with: |  |
| Registration Number: |  |
| Scope of Practice: |  |

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

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

Please circle your answers

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| --- | --- | --- |
| 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  |

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

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

LOGBOOK – *add rows as necessary*

| Date of activity | Name of activity | Location of activity | Source or referent and/or provider details; or Name of facilitator/Speaker | Hours | Evidence provided?*Number 1-3* | Reflective statement provided?*Number 1-2* |
| --- | --- | --- | --- | --- | --- | --- |
| Substantive | General |
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| TOTALS: | 0 | 0 | 0 | 0 |

CERTIFICATE / EVIDENCE 1

CERTIFICATE / EVIDENCE 2

CERTIFICATE / EVIDENCE 3

REFLECTIVE STATEMENTS

**Summary of learning** – What have you learnt? How has the CPD contributed to your body of knowledge and skills?

**Outcomes** – How have you applied this learning to your work and integrated the knowledge and findings into your practice?

**Further Learning** – What further learning could you undertake?

REFLECTIVE STATEMENT 1

Ethical [ ]  Substantive [ ]  Cultural [ ]

REFLECTIVE STATEMENT 2

Ethical [ ]  Substantive [ ]  Cultural [ ]