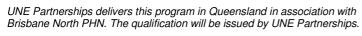
Expression of Interest Form: Course Code HLT47715 Certificate IV in Medical Practice Assisting

Please return form with **all pages and sections completed** to <u>medicalassistant@brisbanenorthphn.org.au</u> or fax to 07 3630 7871

Personal Details						
Surname:				Given Name:		
Date of Birth:				Gender:		
Postal Address:			State:		Postcode:	
Preferred Email Address:				Preferred Phone Number:		
*Please print clearly						
Emergency Contact Name:				Emergency Contact Phone:		
Practice Details						
Place of Employment:			Current Role:			
Employers' Postal Address:	Postal Address:		State:		Pos	stcode:
Work Phone:	Work Fax:			Work email:		
Education						
What is your highest level of education? (tick one box only)			☐ Year 12 or ed☐ Year 11 or ed☐ Year 10 or ed☐	quivalent	_	ear 8 or below ever attended school
In what year did you complete the level of education?						
Qualifications						
completed (please tick applicable boxes)			☐ Bachelor Degree or Higher Degree ☐ Advanced Diploma or Associate Degree			ertificate III (or Trade ficate)
					□С	ertificate II
			Diploma (or Associate Diploma)		□с	ertificate I
			Certificate IV (or Advanced ertificate/Technician)			do not have any of the above fications
Employment						
box only) Southern temployment status? (please tick one box only)			☐ Full time employee☐ Part-time employee☐ Self-employed (not employing others)		famil	mployed (unpaid worker in y business)
					work	,
		☐ Employer			□ U work	nemployed (seeking part time)
						ot employed (not seeking oyment)

Expression of Interest Form: Certificate IV in Medical Practice Assisting Contact: medicalassistant@brisbanenorthphn.org.au, phone 07 3630 7371 or fax 07 3630 7871.







Employer to complete

I [insert name] endorse [insert student name] participating in this program.

I will provide reasonable support during the learning and assessment process in the form of:

- 1. leave from work to attend face to face sessions (if applicable).
- 2. meetings to discuss learning and assessment requirements (if applicable) .
- 3. opportunities to apply the learning and complete administrative and clinical assessment tasks including, time in the practice treatment room and time with clinically trained staff.
- 4. sign verification forms, e.g. reports, on the job training forms and provide testimonials regarding the student's achievements.

, . ,			
Supervisor Details			
Clinical Supervisor:			
Phone Number:	Preferred Email Address:		
Administration Supervisor (if different):			
Phone Number:	Preferred Email Address:		

Clinical Supervisor to complete

Employer Representative Signature:

*Clinical Supervisor must be either a Registered Nurse(RN) or Medical Practitioner

I [insert name] , [insert position]

I will provide clinical supervision during the learning and assessment process in the form of:

- 1. opportunities to apply the learning and complete work-based clinical tasks including time in the practice treatment room and time with clinically trained staff.
- 2. sign verification forms, e.g. reports, on the job training forms and provide testimonials regarding the student's achievements.

Clinical Supervisor Signature:	Date:

Administration Supervisor (if different from above) to complete

I [insert name] endorse [insert student name]

participating in this program.

I will provide reasonable support during the learning and assessment process in the form of:

- 1. leave from work to attend face to face sessions (if applicable) .
- 2. meetings to discuss learning and assessment requirements (if applicable)
- 3. opportunities to apply the learning and complete administrative assessment tasks.
- 4. sign verification forms, e.g. third party reports or on the job training forms, and provide testimonials regarding the student's achievements.

Administration Supervisor Signature Date:

Student Declaration

- 1. I understand that UNE Partnerships delivers this program in Queensland in association with Brisbane North PHN (Partners 4 Health) and that the qualification will be issued by UNE Partnerships.
- 2. I acknowledge that it is my responsibility to enrol correctly.
- 3. I agree to meet all enrolment deadlines and make payment of all fees arising from this enrolment by the due date. I understand that I must accept the consequences of not meeting these due dates in accordance with the instructions either published by Partners 4 Health or sent to me in any correspondence from Partners 4 Health relating to my enrolment.
- 4. I authorise Partners 4 Health to transfer, use and disclose any information provided by me, or any information obtained in connection with this enrolment, to UNE Partnerships and understand that if eligible for funding UNE Partnerships is required to report my information to the Qld Department of Education and Training.
- 5. I authorise Partners 4 Health to collect, receive, store, transfer, use and disclose any information regarding me where Partners 4 Health reasonably considers it is necessary.
- 6. I understand giving of false or misleading information may lead to cancellation of my enrolment.
- 7. I acknowledge that while I am enrolled I will comply with the rules and policies of UNEP Partnerships and Partners 4 Health as amended from time to time
- I declare that the information I have provided in connection with this enrolment is true and complete.

Student Signature:	Date:
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UNE Partnerships delivers this program in Queensland in association with Brisbane North PHN. The qualification will be issued by UNE Partnerships.