

Expression of Interest Form: Course Code HLT47715

Certificate IV in Medical Practice Assisting

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

Personal Details			
Surname:		Given Name:	
Date of Birth:		Gender:	
Postal Address:		State:	Postcode:
Preferred Email Address: *Please print clearly		Preferred Phone Number:	
Emergency Contact Name:		Emergency Contact Phone:	
Practice Details			
Place of Employment:		Current Role:	
Employers' Postal Address:		State:	Postcode:
Work Phone:	Work Fax:	Work email:	
Education			
What is your highest level of education? (tick one box only)		<input type="checkbox"/> Year 12 or equivalent	<input type="checkbox"/> Year 8 or below
		<input type="checkbox"/> Year 11 or equivalent	<input type="checkbox"/> Never attended school
		<input type="checkbox"/> Year 10 or equivalent	
In what year did you complete the level of education?			
Qualifications			
Please specify which of the following, including non-medical, qualifications you have successfully completed (please tick applicable boxes)		<input type="checkbox"/> Bachelor Degree or Higher Degree	<input type="checkbox"/> Certificate III (or Trade Certificate)
		<input type="checkbox"/> Advanced Diploma or Associate Degree	<input type="checkbox"/> Certificate II
		<input type="checkbox"/> Diploma (or Associate Diploma)	<input type="checkbox"/> Certificate I
		<input type="checkbox"/> Certificate IV (or Advanced Certificate/Technician)	<input type="checkbox"/> I do not have any of the above qualifications
Employment			
Of the following categories, which best describes your current employment status? (please tick one box only)		<input type="checkbox"/> Full time employee	<input type="checkbox"/> Employed (unpaid worker in family business)
		<input type="checkbox"/> Part-time employee	<input type="checkbox"/> Unemployed (seeking full time work)
		<input type="checkbox"/> Self-employed (not employing others)	<input type="checkbox"/> Unemployed (seeking part time work)
		<input type="checkbox"/> Employer	<input type="checkbox"/> Not employed (not seeking employment)

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 Contact: medicalassistant@brisbanenorthphn.org.au, phone 07 3630 7371
 or fax 07 3630 7871.

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

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.

Employer Representative Signature: **Date:**

Supervisor Details

Clinical Supervisor:

Phone Number:

Preferred Email Address:

Administration Supervisor (if different):

Phone Number:

Preferred Email Address:

Clinical Supervisor to complete

***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
8. I declare that the information I have provided in connection with this enrolment is true and complete.

Student Signature: **Date:**.....