



Medical Board of Queensland

ABN: 35 789 357 327

# Application for Assessment/Review of Supervised Practice Conditions on General Registration – Form M10

Section 90 Medical Practitioners Registration Act 2001



**Mailing Address:**

Medical Board of Queensland  
GPO Box 1667  
BRISBANE QLD 4001



**Enquiries:**

Telephone: (07) 3234 0176  
Monday to Friday 9.00 am – 5.00 pm  
E-mail [registrations@medicalboard.qld.gov.au](mailto:registrations@medicalboard.qld.gov.au)  
Website [www.medicalboard.qld.gov.au](http://www.medicalboard.qld.gov.au)



**Location:**

Level 11, Forestry House  
160 Mary Street  
BRISBANE QLD 4000

PERSONAL DETAILS				
Family Name / Surname				
Given Names				
Postal Address				
<i>Note: all changes must be notified to the Board</i>		State		Postcode
Is this your residential address? <i>The Board publishes your postal address as your registration address to the public register unless it is your residential address, which will not be published without your agreement</i>				Yes <input type="checkbox"/> No <input type="checkbox"/>
If you answered yes above, do you agree to the Board publishing your residential address to the public register?				Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact Telephone Numbers	Day	Mobile	After Hours	
Email Address				

REASON FOR REVIEW APPLICATION	
Please ✓ appropriate box	
<input type="checkbox"/>	<b>Completion of approved Supervised Practice Program</b> Go to Section A
<input type="checkbox"/>	<b>Completed part of approved Supervised Practice Program and seek further approval for amendment of program / change of facility</b> Go to Section B
<input type="checkbox"/>	<b>Non-commencement of approved Supervised Practice Program and seeking approval for a Supervised Practice Program at another facility</b> Go to Section C

SECTION A	
<b>Completion of Supervised Practice Program (you must submit this notice within 7 days of completing your Supervised Practice Program)</b>	
I hereby give notice that I have completed the program of supervised practice approved by the Medical Board of Queensland and hereby apply to the Board for removal of probationary conditions on my registration.	
Name of Supervisor(s) nominated on approved supervised practice program	
Name of Applicant (Print)	
Signature of Applicant	



#### ATTACHMENT REQUIRED

- Assessment Report (Form M12) from supervisor of supervised practice program for full period of program

**SECTION B****Completed part of approved Supervised Practice Program and seek further approval for amendment of program / change of facility of approved–**

I hereby give notice that I have completed part of the program of supervised practice approved by the Medical Board of Queensland.

I hereby apply to the Board for approval to completed the program of supervised practice at another facility and, if applicable, an extension of time to complete the required supervised practice program

Name of facility of the currently approved supervised practice program

Length of program completed

Reason for leaving the currently approved supervised practice program

Name of facility of the proposed supervised practice program

Name of Applicant (Print)

Signature of Applicant

**ATTACHMENTS (2) REQUIRED**

- Assessment Report (Form M12) from supervisor of currently/previously approved supervised practice program
- Supervised Practice Program to meet the Board's specified requirements from proposed facility

**SECTION C****Non-commencement of approved Supervised Practice Program and seeking approval for a Supervised Practice Program at another facility**

I hereby give notice that I did not commence the program of supervised practice approved by the Medical Board of Queensland.

I hereby apply to the Board for extension of supervised practice conditions to undertake a supervised program at another facility.

Name of facility of the currently approved supervised practice program

Name of facility of the proposed supervised practice program

Reason for non-commencement of the currently approved supervised practice program

Name of Applicant (Print)

Signature of Applicant

**ATTACHMENTS (2) REQUIRED**

- Supervised Practice Program to meet the Board's specified requirements from proposed facility
- Written confirmation from the facility of the currently approved supervised practice program that the supervised practice program was not commenced at that facility

