



**SECTION 1- TO BE COMPLETED BY THE APPLICANT**

Applicant's Name: \_\_\_\_\_ Registration Number: 33-0 \_\_\_\_\_

Email Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

I wish to apply for expanded practise to be added to your annual practising certificate in:  
(Please circle):

PICC                  PACU                  BOTH

I have included the following certified copy documentation with my application

- A current annual practising certificate
- Evidence of meeting all training programme requirements
- Confirmation of competence to perform all competencies required for the expanded practice independently
- Evidence of successfully completing an annual assessment
- Completed logbook detailing all insertions (both successful and unsuccessful) carried out in the past 12 months.
- Evidence of meeting the minimum number of clinical hours/procedures

## Declarations

I declare the following:

- I certify that all the information provided in this application is true and correct in every particular.
- I understand upon approval the Council will place a condition on my annual practising certificate (APC) allowing me to work in an expanded practice role; and
- I will need to apply to have that expanded practice activity included as a condition on my APC each year as a component of the APC application renewal process.
- I understand I will need to provide evidence of continuing professional development activities that relate to the expanded practice activity which have been included as a condition on my APC.
- I understand I can only work in an expanded practice activity that has been approved by the Medical Sciences Council
- All the information provided with this application is true and correct in every particular.
- I declare I have completed all requirements of a hospital-based training programme

**Applicant's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Note:** Under section 172 of the Health Practitioners Competence Assurance Act 2003, any person who commits an offence if they make any declaration or representation that, to their knowledge, is false or misleading, may be liable on summary of conviction to a fine not exceeding \$10,000.00.

**SECTION 2- TO BE COMPLETED BY CLINICAL DIRECTOR OF ANAESTHESIA**

This section needs to be completed by a registered medical anaesthetist who is responsible for the anaesthetic department at the health care facility

Name: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Healthcare Facility: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Position: \_\_\_\_\_

Expanded practice must be focused on meeting patient needs and improving patient outcomes. Expansion of an anaesthetic technician's practice must meet an identified gap(s) in health services. Anaesthetic technicians working in an expanded role must have the required knowledge and skills and have the necessary supports to continue in that role.

## Confirmation of competency in PICC line insertions

I certify that \_\_\_\_\_ (applicant's name) has completed a training programme in PICC line insertions at \_\_\_\_\_ (named healthcare facility) and is competent in the following:

### PICC Line Insertions

- |  |                                     |  |                                     |
|--|-------------------------------------|--|-------------------------------------|
|  | <input checked="" type="checkbox"/> |  | <input checked="" type="checkbox"/> |
| • Ultrasound training for vascular access      | <input type="checkbox"/>            | • Seldinger Technique                        | <input type="checkbox"/>            |
| • CXR Education                                | <input type="checkbox"/>            | • Tip guidance technique                     | <input type="checkbox"/>            |
| • Aseptic technique                            | <input type="checkbox"/>            | • Simulation training of needling techniques | <input type="checkbox"/>            |
| • Informed consent, Time Out and documentation | <input type="checkbox"/>            | • Recommended reading material               | <input type="checkbox"/>            |



**Competence**



- Ability to perform all steps of the procedure independently and according to healthcare facility policy
- Has successfully completed all requirements of the PICC line insertion training programme
- Has the requisite theoretical knowledge

I confirm that \_\_\_\_\_ (applicant's name) is able to perform all components of PICC line insertions in a safe and competent manner and in accordance with the hospitals policy and protocols.

\_\_\_\_\_  
(Signed)

\_\_\_\_\_  
(Date)

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## Confirmation of competency in PACU

I certify that \_\_\_\_\_ (applicant's name) has completed a training programme in PACU at \_\_\_\_\_ (named healthcare facility) and is competent in the following **PACU** standards:

### Airway Management

- |  |   |
|--|---|
| <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   |
| <ul style="list-style-type: none"> <li>• Removal of artificial airways <input type="checkbox"/></li> <li>• Positioning of artificial airways to maintain respiration <input type="checkbox"/></li> </ul> | <ul style="list-style-type: none"> <li>• Maintenance of Universal Precautions <input type="checkbox"/></li> <li>• Selection and preparation of appropriate airway equipment <input type="checkbox"/></li> </ul> |

### Monitoring Assessment and Care

- |  |   |
|--|---|
| <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   |
| <ul style="list-style-type: none"> <li>• Communication with patient <input type="checkbox"/></li> <li>• Monitoring of fluid balance, fluid therapy <input type="checkbox"/></li> <li>• Monitoring of operation sites, drain and wound care <input type="checkbox"/></li> <li>• Drug therapy assessment, assessment of pain <input type="checkbox"/></li> </ul> | <ul style="list-style-type: none"> <li>• Plan of care <input type="checkbox"/></li> <li>• Monitoring of comfort levels and/or adverse reactions <input type="checkbox"/></li> <li>• Monitoring emergencies – respiratory and cardiovascular <input type="checkbox"/></li> <li>• Pharmacology of common drugs used in the PACU phase <input type="checkbox"/></li> </ul> |

### Patient Care Handover

- |  |  |
|--|--|
| <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>  |
| <ul style="list-style-type: none"> <li>• Documentation requirements <input type="checkbox"/></li> <li>• Communication requirements for patient handover <input type="checkbox"/></li> <li>• Accepting handover from the anaesthetist <input type="checkbox"/></li> </ul> | <ul style="list-style-type: none"> <li>• Handing over to ward staff <input type="checkbox"/></li> <li>• Handing over to PACU colleague <input type="checkbox"/></li> </ul> |

### Competence

- |  |
|--|
| <input checked="" type="checkbox"/>  |
| <ul style="list-style-type: none"> <li>• Ability to perform all PACU activities independent and according to the healthcare facility policy <input type="checkbox"/></li> <li>• Has successfully completed all requirements of the PACU training programme <input type="checkbox"/></li> <li>• Has the requisite theoretical knowledge <input type="checkbox"/></li> </ul> |



I confirm that \_\_\_\_\_ (applicant's name) is able to perform all components of PACU in a safe and competent manner and in accordance with the hospital's policy and protocols.

\_\_\_\_\_  
(Signed)

\_\_\_\_\_  
(Date)

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