

Clinical Physiologists Registration Board

ANNUAL PRACTICING CERTIFICATE APPLICATION FORM 2010

Please check and complete all sections of this form using pen and legible English. Please refer to the Registration guidelines with any initial queries prior to contacting the CPRB secretary.

Personal Details

First names		Surname	
Preferred name		Maiden name	
Title		Date of birth	
Work address		Home address	
Department			
Hospital			
Address			
City		City	
Telephone		Telephone	
Fax		Fax	
Email		Email	
Specify preferred correspondence address		Work address	
Please ensure you notify the CPRB of any change of address.			

Registration Status

Registration status		Registration number	
If you currently have provisional registration, have you obtained a qualification which would entitle you to full registration since your last APC application? If the answer is yes, you should complete the registration upgrade form and send it with your APC.			
Scopes of Practice			
SOP 1			
SOP 2			
SOP 3			

Continuing Professional Development (CPD)

Minimum CPD points you require in 2010		Minimum CPD points you require over 3 years	
If you have provisional registration you are not required to obtain CPD.			
Your CPD History			
CPD 2007		CPD 2008	
		CPD 2009	
		Total CPD	
Comments			
For CPD obtained between 1 st June 2009 and 31 st May 2010 complete the table on page 2.			

For official use only

2010 APC awarded (Yes / No)		Date received	
Payment received by		Pending	
		Amount paid	
Scope(s) of practice awarded	1		
	2		
	3		
Assessed by (Board members signature)			
Date APC processed			

Cardiac Procedures (Performed in the last 12 months)			
Please indicate (tick) those procedures you are currently performing on a regular basis			
Procedures Performed	<input type="checkbox"/>	<input type="checkbox"/>	Under supervision (S) or Independent (I)
Average number of cases / month			
Non Invasive Testing – setup, monitoring and recording			
ECG's	<input type="checkbox"/>	<input type="checkbox"/>	
Holter monitor fitting	<input type="checkbox"/>	<input type="checkbox"/>	
Event recorder fitting	<input type="checkbox"/>	<input type="checkbox"/>	
Blood pressure monitor fitting	<input type="checkbox"/>	<input type="checkbox"/>	
ETT's – ECG Technician role	<input type="checkbox"/>	<input type="checkbox"/>	
Tilt table testing	<input type="checkbox"/>	<input type="checkbox"/>	
Non Invasive Testing – analysis and reporting			
Event recorder analysis & reporting	<input type="checkbox"/>	<input type="checkbox"/>	
Blood pressure monitor analysis	<input type="checkbox"/>	<input type="checkbox"/>	
Holter monitor analysis & reporting	<input type="checkbox"/>	<input type="checkbox"/>	
Other Non Invasive Testing			
ETT supervision	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker follow-up	<input type="checkbox"/>	<input type="checkbox"/>	
ICD follow-up	<input type="checkbox"/>	<input type="checkbox"/>	
Adult echocardiography	<input type="checkbox"/>	<input type="checkbox"/>	
Paediatric echocardiography	<input type="checkbox"/>	<input type="checkbox"/>	
Stress echo imaging	<input type="checkbox"/>	<input type="checkbox"/>	
Invasive procedures			
Catheter lab – Coronary & PCI	<input type="checkbox"/>	<input type="checkbox"/>	
Rt heart studies & cardiac output	<input type="checkbox"/>	<input type="checkbox"/>	
Intra aortic balloon pumping	<input type="checkbox"/>	<input type="checkbox"/>	
Temporary pacing	<input type="checkbox"/>	<input type="checkbox"/>	
Paediatric catheterisation studies	<input type="checkbox"/>	<input type="checkbox"/>	
Cryoablation	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker implants	<input type="checkbox"/>	<input type="checkbox"/>	
ICD implants	<input type="checkbox"/>	<input type="checkbox"/>	
Electrophysiology studies	<input type="checkbox"/>	<input type="checkbox"/>	
Other procedures			
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Clinical Supervisors Declaration	
I declare that the information provided for _____ (applicant's name) with regard to work experience and procedures performed, is correct to the best of my knowledge.	
Clinical supervisors name (printed)	
Clinical supervisors signature	
Supervisors position	
Date	

Respiratory Procedures (Performed in the last 12 months)				
Please indicate (tick) those procedures you are currently performing on a regular basis				
Procedures Performed	<input type="checkbox"/>	<input type="checkbox"/>	Under supervision (S) or Independent (I)	Average number of cases / month
Non Invasive Diagnostic Respiratory Recordings				
Pulse Oximetry	<input type="checkbox"/>	<input type="checkbox"/>		
Capnography	<input type="checkbox"/>	<input type="checkbox"/>		
Inspiratory / Expiratory ventilation and gas exchange	<input type="checkbox"/>	<input type="checkbox"/>		
Nutritional assessment through ventilation	<input type="checkbox"/>	<input type="checkbox"/>		
Non Invasive Diagnostic Respiratory and Cardio-respiratory Testing				
Spirometry	<input type="checkbox"/>	<input type="checkbox"/>		
Static Lung Volumes	<input type="checkbox"/>	<input type="checkbox"/>		
Diffusing Capacity of the Lung	<input type="checkbox"/>	<input type="checkbox"/>		
Response to Bronchodilator	<input type="checkbox"/>	<input type="checkbox"/>		
Inspiratory / Expiratory Mouth Pressures	<input type="checkbox"/>	<input type="checkbox"/>		
Cardiopulmonary response to Exercise	<input type="checkbox"/>	<input type="checkbox"/>		
Shunt	<input type="checkbox"/>	<input type="checkbox"/>		
Sputum Induction	<input type="checkbox"/>	<input type="checkbox"/>		
Direct and Indirect Diagnostic Challenge testing for Identifying Active Bronchial Hyper-				
Hypertonic Saline	<input type="checkbox"/>	<input type="checkbox"/>		
Methacholine	<input type="checkbox"/>	<input type="checkbox"/>		
Histamine	<input type="checkbox"/>	<input type="checkbox"/>		
Eucapnic Voluntary Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>		
Manitol	<input type="checkbox"/>	<input type="checkbox"/>		
Exercise	<input type="checkbox"/>	<input type="checkbox"/>		
Diagnostic Exercising testing				
Full Cardiopulmonary Exercise	<input type="checkbox"/>	<input type="checkbox"/>		
6 / 12 Minute Walk and Step	<input type="checkbox"/>	<input type="checkbox"/>		
Diagnosis and Assessment of Requirement for Domiciliary Oxygen				
Hypoxia Inhalation Test (HIT)	<input type="checkbox"/>	<input type="checkbox"/>		
Supplementary Oxygen Assessment	<input type="checkbox"/>	<input type="checkbox"/>		
Invasive Diagnostic Test and Investigation Procedures				
Arterial Blood Gas Sampling	<input type="checkbox"/>	<input type="checkbox"/>		
Arterialised venous Blood Sampling	<input type="checkbox"/>	<input type="checkbox"/>		
Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy Skin Prick	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberculin (Mantoux)	<input type="checkbox"/>	<input type="checkbox"/>		
Intracutaneous	<input type="checkbox"/>	<input type="checkbox"/>		
Blood gas Analysis	<input type="checkbox"/>	<input type="checkbox"/>		
Tonometry	<input type="checkbox"/>	<input type="checkbox"/>		
Other procedures				
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Clinical Supervisors Declaration	
I declare that the information provided for _____ (applicant's name) with regard to work experience and procedures performed, is correct to the best of my knowledge.	
Clinical supervisors name (printed)	
Clinical supervisors signature	
Supervisors position	
Date	

Sleep Procedures (Performed in the last 12 months)			
Please indicate (tick) those procedures you are currently performing on a regular basis			
Procedures Performed	<input checked="" type="checkbox"/>	Under supervision (S) or Independent (I)	Average number of cases / month
Polysomnography			
Level I Studies (attended polysomnography)			
Setup	<input type="checkbox"/>		
Analysis	<input type="checkbox"/>		
Level II Studies (unattended polysomnography)			
Setup	<input type="checkbox"/>		
Analysis	<input type="checkbox"/>		
Level III Studies (Cardiorespiratory and recordings)			
Setup (eg. Embletta)	<input type="checkbox"/>		
Analysis	<input type="checkbox"/>		
Level IV Studies (single/dual/channel recordings)			
Setup (eg. Oximetry)	<input type="checkbox"/>		
Analysis	<input type="checkbox"/>		
Positive Pressure Ventilation			
Patient Education	<input type="checkbox"/>		
CPAP Titration	<input type="checkbox"/>		
BI-Titration	<input type="checkbox"/>		
Technical Follow up	<input type="checkbox"/>		
Other procedures			

Clinical Supervisors Declaration	
I declare that the information provided for _____ (applicant's name) with regard to work experience and procedures performed, is correct to the best of my knowledge.	
Clinical supervisors name (printed)	
Clinical supervisors signature	
Supervisors position	
Date	

Other information to support your APC application

Declaration	
<p>I wish to apply for an annual practicing certificate and I consent to the Clinical Physiologists Registration Board obtaining confidential verbal or written information about my professional experience and current role for the purpose of assessing my registration and APC eligibility. I understand that my registration status will be published in the CPRB register and made known to my clinical supervisor.</p> <p>I declare that the information I have supplied in this application (and other supporting information provided) is true and correct to the best of my knowledge. I accept that false declaration or failure to disclose relevant information could result in my removal from the register.</p> <p>I declare that I have no mental or physical conditions I am aware of that may compromise my competence and therefore compromise the safety of patients.</p>	
Applicants name (printed)	
Applicants signature	
Date	

Payment		
Amount due for APC: Provisional Registration - no payment required		
<p style="text-align: center;">Upgrading Registration - please provide upgrade form - \$150 (APC) + \$ 150 (Upgrade)</p> <p style="text-align: center;">No Change in Registration Status - \$150</p>		
Payment method	Cheque (made out to CPRB)	Internet banking Account Number: 38-9006-0514863-000 Account Name: Clinical Physiologists Registration Board Reference: Surname / Registration number

Please send your completed form and payment to:		
Secretary Clinical Physiologists Registration Board c/- Cardiac Physiology, Level 3 Auckland City Hospital Private Bag 92024 Auckland	Telephone: +64 9 630 9929 Facsimile: +64 9 630 9877 Email: fionar@adhb.govt.nz Website: www.sct.org.nz	

Checklists for Registration and APC Applications

Annual Practicing Certificate Application Form		
Check the following are correctly completed prior to sending your forms.	Your check	CPRB check
Previously registered with CPRB or Initial / Upgrade registration application also completed		
Personal details and registration status correctly completed		
Current work experience completed		
Qualifications obtained since last APC application completed		
Certified copies of all qualifications are attached		
Cardiac procedures completed		
Respiratory procedures completed		
Sleep procedures completed		
Clinical supervisors declaration signed for each procedures page		
Declaration signed by applicant		
APC fee enclosed		

Initial and Upgrade of Registration		
Check the following are correctly completed prior to sending your forms and attach this checklist to your application.	Your check	CPRB check
Annual practicing certificate form also completed (<i>if applicable</i>)		
Personal details and registration status correctly completed		
Relevant membership with a professional body attained or simultaneously applied for		
Current and previous qualifications section completed correctly		
Proof of acceptance into the Post Graduate Certificate/Diploma in Medical Technology by Otago University attached (<i>if relevant</i>)		
Certified copies of all qualifications are attached		
Current CV attached (Initial registration only)		
Relevant work experience - current and previous employment details correctly completed		
Practical Training section correctly completed (<i>if relevant</i>)		
Declaration signed by applicant		
Registration fee enclosed		