



MORE DOCTORS FOR OUTER METROPOLITAN AREAS MEASURE

Application for the Relocation Incentive Grant

This form must be completed if you:

- Wish to apply for a relocation incentive payment under the More Doctors for Outer Metropolitan Areas Measure; and
- You are not a non-vocationally recognised GP who is also applying for access to the A1 rebate.

The financial assistance grant is only available until 31 December 2004. All applications must be received on or before 31 December 2004.

[For advice on the financial assistance grant or assistance with this application, please call the Outer Metro Hotline 1800 727 899.](tel:1800727899)

Please note, Medicare provider number information supplied will be checked to validate your eligibility for the financial assistance grant.

The application grant includes this application form plus an accompanying fact sheet and is found at www.health.gov.au/workforce/new/more.htm

*Completed applications may be sent to:
The Delegate - More Doctors for Outer Metropolitan Areas Measure
MDP 78 GPO Box 9848
CANBERRA ACT 2601*

Please tick where appropriate.

Part 1 PERSONAL INFORMATION

Title

For office use only -
Application Registration No.

Gender

Male

Female

Family name

First names

Postal address

Daytime phone number

Mobile phone number



Fax number

Email address

Preferred method of contact - (*can be more than one*)

Daytime
phone no.

Mobile
phone no.

Fax

Email

Were you an Australian Citizen on 1 November 1996?

Yes

No

Were you a Permanent Resident on 1 November 1996?

Yes

No

N/A

(If yes, please provide a copy of pages from your passport showing personal details and any visa issued authorising your stay in Australia and the Australian entry stamp)

Other.....

(New Zealand citizens - Persons entering Australia on a New Zealand passport enter on a temporary visa and cannot hold Australian permanent resident status)

Did you complete your Australian internship prior to 1 November 1996?

Yes

No

N/A

If you are an overseas trained doctor and were required to sit the AMC exams, did you complete ALL AMC requirements prior to 1 November 1996?

Yes

No

N/A

When did you gain your unconditional (general) medical registration in Australia?

Are there any conditions on your medical registration?

Yes

No

Do you have a current Medicare provider number?

Yes

No

Are there any restrictions on the use of your Medicare provider number?

Yes

No

(This includes restrictions under section 19AA of the *Health Insurance Act 1973*)



Medicare provider number/s

Are you a:

Non VR General Practitioner

VR General Practitioner

Specialist*

*Please indicate your specialty.

Current practice name

Current practice address (*street address*)

Suite	Level	Building
Street number	Street name	
Suburb		State
Postcode		

Other practice address if applicable

Suite	Level	Building
Street number	Street name	
Suburb		State
Postcode		

Please attach the practice addresses for any additional practices.



Part 2 PRACTICE RELOCATION DETAILS

Are you considering setting up a new practice?

Yes

No

If yes, are you planning to establish a solo or group practice?

Solo practice

Group practice

N/A

If you are planning a group practice please provide the name/s of the other doctors applying for the Relocation Incentive Grant participating doctors if known.

Have you already received advice that the practice site has been approved for the Program?

Yes

No

Please nominate preferred locations if known.

No.1 Proposed relocation practice name if known

When do you intend to relocate to this practice?

Preferred employment status

Full time

Part time

(No. of hours/week - approx)*

*these details are required by the delegate to calculate the relocation incentive payment to which you are entitled



Practice address

Suite	Level	Building
Street number	Street name	
Suburb		State
Postcode		

No. 2 Proposed relocation practice name if known

When do you intend to relocate to this practice?

Date:	/	/
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Preferred employment status

<input type="checkbox"/>	Full time	(No. of hours/week - approx)*
<input type="checkbox"/>	Part time	(No. of sessions/week)*

*these details are required by the delegate to calculate the relocation incentive payment to which you are entitled

Practice address

Suite	Level	Building
Street number	Street name	
Suburb		State
Postcode		



Part 3 DECLARATION AND CONSENT OF INFORMATION

Privacy Note

The information provided by you on this form will be used to assess your eligibility to participate in the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program. Where appropriate, and in order to ensure correct administration of the Program, information may be exchanged between the Department and the Health Insurance Commission (HIC) for the purposes of administering, monitoring, reviewing and evaluating the Program. Please note that any information you have supplied to the HIC and/or the Department of Health and Ageing in connection with your application for the Program will be dealt with in accordance with the provisions of the *Privacy Act 1988*, and in particular, the Information Privacy Principles set out in section 14 of that Act.

Declaration

I declare that the information I have supplied in this form is true and correct. I consent to the release of information by the Health Insurance Commission to the Department of Health and Ageing, or vice versa, for the purposes of administering, monitoring, reviewing and evaluating the Program.

Signature.....

Date.....

I understand that there are penalties for supplying false or misleading information regarding provider numbers and practice locations.



OFFICE USE ONLY

Application Registration No:

Approved practice location

Geocode status

Approved Relocation Incentive Payment amount

No. of sessions (hours)/week	FTE =
\$	

Application approved / /2004

Delegate signature

Application not approved / /2004

Reason

Delegate signature

Additional practice addresses if more than one practice location is approved.