



# MORE DOCTORS FOR OUTER METROPOLITAN AREAS MEASURE

Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program

## APPLICATION FORM – RETENTION COMPONENT

**For advice on this Program and/or assistance with this application, please call the Program hotline: 1800 727 899**

*Please note, Medicare provider number information supplied will be checked to validate your eligibility for the Program.*

*Guidelines referred to in the application are the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program Relocation Component Guidelines located at [www.health.gov.au/workforce/new/more.htm](http://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

Citizenship status

- Australian citizen       Permanent resident  
 Other.....

Date of original Australian medical registration

State of current medical registration

- ACT       NT       SA       VIC  
 NSW       QLD       TAS       WA

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

Medicare provider number/s

No.1 practice name



ABN

No.1 practice address (*street address*)

Suite	Level	Building
Street number	Street name	
Suburb	State	
Postcode		

No.2 practice name

ABN

No.2 practice address (*if applicable*)

Suite	Level	Building
Street number	Street name	
Suburb	State	
Postcode		

*Please attach the practice addresses for any additional practices you work at.*

Additional qualifications



## Part 2 RACGP FELLOWSHIP

*(Please refer to section 9 of the Guidelines)*

Are you currently enrolled in a pathway to Fellowship of the RACGP?

Yes      please provide a copy of       No  
   enrolment advice

Are you currently enrolled for assessment for Fellowship of the RACGP?

Yes      please provide a copy of       No  
   assessment advice

Are you currently enrolled in the General Practice Recognition Educational Program administered by General Practice Education Australia Limited?

Yes      please provide a copy of       No  
   enrolment advice

I am committed to completing a pathway to Fellowship of the RACGP within stipulated Program Guideline requirements.

Yes       No

## 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 and 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.



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**OFFICE USE ONLY**

Application Registration No:

Approved practice location

Geocode status

Application Approved / /2004

Delegate signature

Application Not Approved / /2004

Reason

Delegate signature

*Please attach the practice addresses for any additional practices that are approved for this Program.*