AUSTRALASIAN COLLEGE OF
SPORT AND EXERCISE PHYSICIANS

3GA

3GA – Verification of Approved Placement Form

DESCRIPTION

Registrars must complete this form for any placements they will be training at including ACSEP Accredited Training Practices (AATPs), hospitals or other sport and exercise medicine-related clinics or settings AND when a Medicare Provider Number is required. Medicare processing times can be lengthy, and it is recommended this form be completed as soon as possible before commencing in the placement. Completed forms must be submitted to registrars@acsep.org.au along with a Medicare HW019 form and National Office will complete the provider number application on the Registrar's behalf.

REGISTRAR DETAILS

Registrar name		Year	
Registrar address *Street number, street, state, postcode, country*			
Stage of training		Training period	
Full-time or part-time		Loading	

PLACEMENT DETAILS

Placement type	☐ ACSEP Accredited Training Practice ☐ Hospital ☐ Other clinic		
Business name			
Business address *Street number, street, state, postcode, country*			
Start date		End date	
Average hours per week at placement		Years worked at placement	
Primary supervisor name		Usual level of supervision	

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Primary supervisor signature		Provider number	
		Date	

MEDICARE PROVIDER NUMBER

Complete ONE of the following options. A HW019 form must be submitted to National Office along with this 3GA form.

☐ NEW Medicare Provider Number required for this location *HW019 Medicare Form is required*		☐ EXTENSION of Medicare Provider Number already at this location *HW019 Medicare Form is required if original Provider Number end date has lapsed or will lapse within 8 weeks*	
Previous Provider Number for Medicare to search with		*Provider Number to extend*	

DECLARATION BY REGISTRAR

I have read, understood and agree to abide by the requirements as described by the ACSEP in regard to working at a training placement and accessing Medicare benefits for the purpose of completing the ACSEP Specialist Training Program. I authorise the ACSEP to provide this from to the Department of Health and Aged Care for the purpose of creating a Medicare Provider Number.

Registrar signature		Date	

DECLARATION BY THE ACSEP

On the advice of the Chairperson of the Committee responsible for the ACSEP Specialist Training Program, I certify that:

- The applicant is an enrolled Registrar in the ACSEP Specialist Training Program and the details regarding the applicant's approved training placement in this application are accurate.
- The placement is part of the structured Training Program of the ACSEP and provides experience not available in a public hospital.
- The placement is an accredited advanced training placement that fully counts toward Training Time and completion of other Training Program requirements.
- Appropriate supervision will be provided at the training placement.

Delegate name and position		College stamp	
Date			

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PLACEMENT AND TRAINING INFORMATION

Past and current AATPs		
Clinical Training Supervisor(s) at proposed AATP	Primary CTS name	
	Other CTS name (if required)	
	Other CTS name (if required)	
	Other CTS name (if required)	
Registrar's reasons for why working at the proposed AATP will benefit their training		

ZONE TRAINING COORDINATOR SIGNOFF

ZTC approval	☐ Placement approved ☐ Placement not approved		
ZTC name		Signature	
Date			