



NEW DIETITIAN PRESCRIBER TRAINING COURSE 6 September 2019

To apply you must meet all the criteria as per the declaration on page 2 and the attached policy
Please provide payment of \$300.00 incl. GST with this application.

I wish to apply to the Dietitians Board to attend the Dietitian Prescriber Training Course.

On successful completion of the course I understand I will have the endorsement of Dietitian Prescriber added to my Scope of Practice on my APC and this endorsement will be noted on the Public Register.

PLEASE PRINT CLEARLY

Full name: _____ Registration No 20-0_____

My current **residential** address is:

My current **postal** address is, if different from residential:

_____	_____
_____	_____
_____	_____

My current **work** address:

Home telephone number:

_____	_____
_____	_____

Work telephone number:

_____	_____
_____	_____

Designated position:

Mobile number:

_____	_____
_____	_____

Board Use:

Date Fee Banked:

Approved:
Yes/No

- Placed on list
- Details checked
- Supervisor
- MOODLE

- Receipt
- Course details
- Outcome
- APC updated

DECLARATION

Please read the all information including the Prescribing Policy carefully before signing.

By signing the declaration below, you are agreeing to abide by the Dietitians Board's conditions of application, including annual monitoring, and understand that you are required to complete and pass the on-line course by 4 September 2019. You will not be permitted to attend the study day and your \$300.00 will **not** be refunded if you have not successfully completed the course, unless you have made at least one attempt and can provide a valid explanation for why you have not met the requirements.

I declare that:

1. I have identified a suitable prescribing supervisor who is in agreement with my application to prescribe Special Foods and certain vitamins and mineral and has **signed** the application form provided with this application.
2. I have not been convicted by any court in New Zealand or elsewhere of any offence punishable by imprisonment for a term of 3 months or longer.
3. I do not have a mental or physical condition that precludes me functioning as a safe and competent practitioner.
4. I am not the subject nor have ever been the subject of professional discipline or competence review by the [Dietitians Board \(NZ\)](#) or any other health occupational registration authority.
5. I am of good professional and personal standing, i.e. I have no unresolved issues, complaint or competence review in process, as at the date of this application.
6. I therefore know of no information that could cause the Dietitians Board not to be satisfied that I am a fit and competent person to be a Dietitian Prescriber.
7. I have read the attached information. I will provide the Dietitians Board with any further information it may require.
8. I declare I will abide by the Board's policy for '[Dietitian Prescribers](#)'. I understand that if the Board deems that I am not suitable for the course, they will return my fee.
9. I understand that once I have been endorsed as a Dietitian Prescriber I am required to undertake and pass the Annual Dietitian Prescribers Update each year.
10. All of the information provided with this application is true and correct in every particular detail.

If you cannot make any of the above declarations, strike it out and state why below:

Applicant's Full Name _____

Applicant's Signature _____

Dated _____

PRESCRIBING SUPERVISOR ENDORSEMENT

You will need to identify a prescribing supervisor. A prescribing supervisor must be a prescriber, either a prescribing dietitian with a **minimum** of 3 years clinical experience in New Zealand dietitian or a Medical Practitioner or other prescriber with knowledge of nutrition, with whom you work. Please refer to the Board's Prescribing Policy on identifying a prescribing supervisor.

The Board must be notified of any change to prescribing supervisors at any time.

I, _____

(full name of Supervisor), agree that

(name of applicant)

fulfils the Board's criteria and will be a suitable person to train as a 'Dietitian Prescriber' and I am willing to supervise this dietitian.

(Signature of Supervisor)

Supervisor's Designation: _____

Supervisor's Occupation: _____

Supervisor's Email address: _____

Supervisor's Place of work: _____

Date: _____

Supervisor's Comments (If Any): _____

PAYMENT DETAILS

This notice becomes a Tax Invoice when paid

GST No: 73-081-114

Name: _____

Registration Number: 20-0 _____

I have paid by **Internet Banking**

(Bank Account for payment **03-0502-0254-940-000** please reference your registration number and surname)

OR

CREDIT CARD: (*tick one*) Visa Mastercard

Card Number

Expiry Date: Month/Year _____ / _____ Amount (NZ\$) _____

Cardholder's
Name _____ Signature: _____

CHECKLIST FOR APPLICANTS (Tick when completed)

- Correctly completed application form
- Payment of \$300.00
- Completed Prescriber Supervisor Endorsement – Supervisor's Name/Signature

Please post documentation to:

Dietitians Board

PO Box 9644

Wellington 6141