

## GP application to register as a provider of focussed psychological strategies

### Section 1: General information

<b>Name:</b>						<b>RACGP or ACRRM Number:</b>								
<b>Preferred mailing address:</b>						<b>Provider Number:</b>								
<b>City, state:</b>						<b>Business hrs ph:</b>								
					Post Code:	<b>Business hrs fax:</b>								
	Is this your: <input type="checkbox"/> Practice address <input type="checkbox"/> Home address <input type="checkbox"/> Other					<b>Mobile: (optional)</b>								
<b>Email address:</b>						Do you consent to receiving updates from the GPMHSC via your email address? <input type="checkbox"/> YES <input type="checkbox"/> NO								
<b>Division of GP:</b>						Do you consent to the GPMHSC disclosing your registration status to your Division? <input type="checkbox"/> YES <input type="checkbox"/> NO								

### Section 2: GPMHSC recognised mental health skills training

Please provide details of recent education and training recognised by the GPMHSC. Supporting documentation in the form of certificates of completion or equivalent (eg. CPD statements) **must be attached** to this application.

#### PATHWAY 1: Completion of formally accredited training

**Step 1:** Completion of GPMHSC recognised training in **mental health assessment and care planning** ('Level One Mental Health Skills Training')

Training Provider	Course Title	Date of Completion
		D D M M Y Y

**Step 2:** Completion of GPMHSC recognised training in **focussed psychological strategies** ('Level Two Mental Health Skills Training')

Training Provider	Course Title	Date of Completion
		D D M M Y Y

**OR**

#### PATHWAY 2: Application for individual assessment and recognition of prior learning

Complete, sign and attach the 'Application for individual assessment and recognition of prior learning', available from [www.racgp.org.au/mentalhealth](http://www.racgp.org.au/mentalhealth)

### Section 3: Consent to disclosure of personal information and confirmation of application

**I consent to** the information provided on this form being used by the General Practice Mental Health Standards Collaboration to assess whether I have completed appropriate education and training to provide focussed psychological strategies services. I understand that the outcome of this assessment and the information collected on this form may be disclosed to Medicare Australia which maintains a register of practitioners who are eligible to provide focussed psychological strategies to patients. I also understand that this information may be disclosed to the Department of Health and Ageing. **I confirm that** I wish to apply for recognition as a GP provider of focussed psychological strategies to patients, and confirm that I have reviewed and am familiar with the requirements for provision of these services as detailed in the Medicare Benefits Schedule.

**Your signature:**

**Date:**

D	D	M	M	Y	Y