Medical Council OF NEW SOUTH WALES

# Breath-testing supervisor nomination form

**Complete this form and send it to us within 2 business days of the participant providing it to you.**

**Email: medicalcouncil.monitoring@mcnsw.org.au or Fax: 02 9816 5307**

**If you are unable to accept the supervisor nomination, please let us know immediately.**

Date ____________________

Your title and name ____________________

Participant's name ____________________

Relationship to the participant ____________________

Are you a registered health practitioner?

☐ **Yes**

Type of health practitioner ____________________

Registration number ____________________

Do you have conditions on your registration?

☐ Yes
Please provide any relevant details

☐ No

Are you the subject of a complaint or active investigation?

☐ Yes
Please provide any relevant details

☐ No

☐ **No** ____________________

**Please provide details of your profession and any identification i.e. registration numbers**

I confirm:

I have read and understood the following documents: ☐ Yes ☐ No

- the operating instructions for the breath-testing device
- the Council's *Alcohol screening policy* and *Participant procedure: breath-testing for alcohol*
- the Council's *Supervisor procedure: breath-testing for alcohol*

I agree to comply with the *Supervisor procedure: breath-testing for alcohol* ☐ Yes ☐ No

I agree to inform the Council if the participant has a positive breath-test, does not attend for breath-testing as required, or if I have any other concerns about their compliance with the conditions on their registration ☐ Yes ☐ No

☐ I confirm that I am not a friend, family member or employee of the participant

I consent to being a breath-testing supervisor for, ______________________

______________________ ______________
Your signature Date

**Your contact details**

Telephone ______________________

Email ______________________

Mailing address ______________________

______________________

**Office use only**

Date of receipt

Complies with relevant criteria ☐ Yes ☐ No Reason/s

PO initials and date

Approval by Council Delegate ☐ Yes ☐ No Reason/s

Council Delegate name, signature and date

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