

**Special Approved Placements Program**

Placement extension request

This form is for existing SAPP participants only. All fields are compulsory unless otherwise indicated.

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| **Application details** |
| Participant’s surname |  |
| Participant’s given names |  |
| Australian residency status |  |
| Medical registration number |  |
| Medicare provider number |  |
| Contact number |  |
| Email address |  |
| Name and address of existingapproved SAPP location/s |  |
| Expiry date of current SAPPplacement |  |
| **Supporting evidence checklist** |
| Current medical registration |  Attached |
| Employment contract |  Attached |
| Eligibility to sit examinations | * General Practice Experience report attached
* Prior exam results attached
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| Evidence of future examination enrolments |  Attached |
| Documentary evidence of exceptional circumstances *If applicable* | * Attached - I am aware this evidence may be referred to Health’s Medical Advisor for comment
* Documentation is from a health professional who is registered in Australia and who does not have a personal or employment relationship with me or my employer. The document demonstrates why the medical condition requires treatment in a specific location
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| Name: |  |
| Signature: |  |
| Date: |  |