

**RECERTIFICATION AUDIT 2025**

SUPERVISOR/EMPLOYER DECLARATION

To be completed by a registered medical imaging technologist, radiation therapist, nuclear medicine technologist, magnetic resonance imaging technologist, sonographer (e.g. line manager) or a radiologist.

Name of Practitioner:

Registration Number: 40-0\_\_\_\_\_\_\_\_\_

Please circle your answers

|  |  |  |
| --- | --- | --- |
| The practitioner has completed the required clinical hours in the stated scope of practice. | Yes | No |
| The practitioner has received a satisfactory performance appraisal that demonstrates competence within the last 12 months in the stated scope of practice. | Yes | No |
| I am satisfied that the practitioner complies with the Code of Ethical Conduct. | Yes | No |
| I am satisfied that the practitioner is physically and mentally fit and competent to practise. | Yes | No |

Supervisor/Employer Name:

Position:

|  |  |
| --- | --- |
| Registered as Health Practitioner with: |  |
| Registration Number: |  |
| Scope of Practice: |  |

Supervisor/Employer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_