



OFFICE OF The Senior Practitioner

Guidance note: Application for Authorisation to Use a Restrictive Practice

This is a summary of the contents of the Application for Authorisation to Use a Restrictive Practice. It is **NOT** an application form.

This form is for disability services providers (providers) to apply to the Senior Practitioner for authorisation to use restrictive practices pursuant to Part 7 of the *Disability, Rights, Inclusion and Safeguarding Act 2024* (the Act).

A provider must seek authorisation from the Senior Practitioner if the provider intends to use a restrictive practice in relation to a person with disability.

The Senior Practitioner may approve or refuse to approve the authorisation of a restrictive practice. An authorisation may be subject to conditions or limitations as the Senior Practitioner considers appropriate.

If the provider does not agree with the decision of the Senior Practitioner, they can ask for a review. In the first instance, re-views will be undertaken by the Office of the Senior Practitioner. If the provider is not satisfied with the outcome of the re-view, they can lodge an application for review with the Tasmanian Civil and Administrative Tribunal (TASCAT).

If more than one provider is seeking authorisation to use a restrictive practice, the providers may choose to use one application form or they may choose to make separate applications in relation to the same person. If you choose to use one application, you can include up to three additional providers in this application. To include additional providers, you would need their contact information and information about their appointed program officer. If there are more than three additional providers, the subsequent providers will need to submit a separate application.

Please note your responses cannot be saved until you submit your application. If you exit the application before submitting it, you will need to s

This application will be submitted electronically. Once submitted, if the applicant is not the APO, the APO will receive an email which will prompt them to identify a suitable person to be the Independent Person.

For more information on this form or the use of restrictive practices for people with disability in Tasmania, contact the Office of the Senior Practitioner at: seniorpractitioner@dpac.tas.gov.au

Person this application is about

This application refers to the person this application is about as 'the person'. It refers to the person with disability.

Title *

- ☐ Mr
- ☐ Master
- ☐ Miss
- ☐ Ms
- ☐ Mrs
- ☐ Mx
- ☐ Other

Given Name *

Family Name *

Other names the person may be known by

Date of Birth *



How does the person describe their gender? *

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

- ☐ Man or male
- ☐ Woman or female
- ☐ Non-binary
- ☐ Prefer not to say
- ☐ Other

Phone No.

The value must be a number

Email

Please enter an email

Residential Address *

What type of accommodation is this? *

Please choose the option that best describes the person's accommodation.

- ☐ Supported Independent Living (SIL)
- ☐ Short term accommodation (Respite)
- ☐ Home of friend or family member
- ☐ Privately owned or rented
- ☐ No fixed address
- ☐ Other

Is the person of Aboriginal or Torres Strait Islander origin? *

- ☐ No
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, both Aboriginal and Torres Strait Islander
- ☐ Don't know

Is the person from a culturally or linguistically diverse background? *

- ☐ Yes
- ☐ No
- ☐ Don't know

The applicant (Disability Services Provider)

Name of your organisation (provider) *

Is your organisation a registered NDIS disability services provider? *

- ☐ Yes
- ☐ No
- ☐ Undergoing registration process

Applicant Title *

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx

Applicant Given Name *

Applicant Family Name *

Applicant Position Title *

Applicant Phone No. *

The value must be a number

Applicant Email *

Please enter an email

Provider Address *

Does your organisation receive funding under the NDIS to provide a service specifically for the support of people with disability? *

- ☐ Yes
- ☐ No
- ☐ Don't Know

What kind of support does your organisation provide to the person this application is about? *

Select all that apply

- ☐ Accommodation (SIL)
- ☐ Accommodation (CSS/OoHC)
- ☐ Accommodation (Respite)
- ☐ Day Support
- ☐ Other

Appointed Program Officer

Appointed Program Officer (APO) Title *

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

APO Given Name *

APO Family Name *

APO Phone No. *

The value must be a number

APO Email *

Please enter an email

Has the appointment of the APO been approved by the Senior Practitioner? *

- ☐ Yes
- ☐ No

What is the APO's ID (this can be found in the APO's approval letter) *

The value must be a number

Additional Providers

Are any other providers providing a service to the person? *

- ☐ Yes
- ☐ No

If there are other providers, will they be implementing the proposed restrictive practice? *

- ☐ Yes
- ☐ No

If yes, are you seeking authorisation for the use of a restrictive practice, on behalf of those additional providers? *

- ☐ Yes
- ☐ No

If no, has the other provider(s) submitted a separate application for authorisation? *

- ☐ Yes
- ☐ No

Additional Provider 1

Name of the Additional Provider 1

Is the Additional Provider 1 a registered NDIS disability services provider?

- ☐ Yes
- ☐ No
- ☐ Undergoing registration process

Additional Provider 1 Contact Person Title

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx

Additional Provider 1 Contact Person Given Name

Additional Provider 1 Contact Person Family Name

Additional Provider 1 Contact Person Position Title

Additional Provider 1 Contact Person Phone No.

The value must be a number

Additional Provider 1 Contact Person Email

Please enter an email

Additional Provider 1 Address

Does Additional Provider 1 receive funding under the NDIS to provide a service specifically for the support of people with disability?

- ☐ Yes
- ☐ No
- ☐ Don't Know

What kind of support does Additional Provider 1 provide to the person this application is about?

Select all that apply

- ☐ Accommodation (SIL)
- ☐ Accommodation (CSS/OoHC)
- ☐ Accommodation (Respite)
- ☐ Day Support
- ☐ Other

Additional Provider 1 Appointed Program Officer

Additional Provider 1 Appointed Program Officer (APO) Title

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

Additional Provider 1 APO Given Name

Additional Provider 1 APO Family Name

Additional Provider 1 APO Phone No.

The value must be a number

Additional Provider 1 APO Email

Please enter an email

Has the appointment of the Additional Provider 1 APO been approved by the Senior Practitioner?

- ☐ Yes
- ☐ No

What is the Additional Provider 1 APO's ID (this can be found in the APO's approval letter)

The value must be a number

Are there other additional providers? *

☐ Yes

☐ No

Additional Provider 2

Name of the Additional Provider 2

Is the Additional Provider 2 a registered NDIS disability services provider?

☐ Yes

☐ No

☐ Undergoing registration process

Additional Provider 2 Contact Person Title

☐ Mr

☐ Mrs

☐ Ms

☐ Miss

☐ Mx

Additional Provider 2 Contact Person Given Name

Additional Provider 2 Contact Person Family Name

Additional Provider 2 Contact Person Position Title

Additional Provider 2 Contact Person Phone No.

The value must be a number

Additional Provider 2 Contact Person Email

Please enter an email

Additional Provider 2 Address

Does Additional Provider 2 receive funding under the NDIS to provide a service specifically for the support of people with disability?

- ☐ Yes
- ☐ No
- ☐ Don't Know

What kind of support does Additional Provider 2 provide to the person this application is about?

Select all that apply

- ☐ Accommodation (SIL)
- ☐ Accommodation (CSS/OoHC)
- ☐ Accommodation (Respite)
- ☐ Day Support
- ☐ Other

Additional Provider 2 Appointed Program Officer

Additional Provider 2 Appointed Program Officer (APO) Title

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

Additional Provider 2 APO Given Name

Additional Provider 2 APO Family Name

Additional Provider 2 APO Phone No.

The value must be a number

Additional Provider 2 APO Email

Please enter an email

Has the appointment of the Additional Provider 2 APO been approved by the Senior Practitioner?

- ☐ Yes
- ☐ No

What is the Additional Provider 2 APO's ID (this can be found in the APO's approval letter)

The value must be a number

Are there other additional providers? *

☐ Yes

☐ No

Additional Provider 3

Name of the Additional Provider 3

Is the Additional Provider 3 a registered NDIS disability services provider?

☐ Yes

☐ No

☐ Undergoing registration process

Additional Provider 3 Contact Person Title

☐ Mr

☐ Mrs

☐ Ms

☐ Miss

☐ Mx

Additional Provider 3 Contact Person Given Name

Additional Provider 3 Contact Person Family Name

Additional Provider 3 Contact Person Position Title

Additional Provider 3 Contact Person Phone No.

The value must be a number

Additional Provider 3 Contact Person Email

Please enter an email

Additional Provider 3 Address

Does Additional Provider 3 receive funding under the NDIS to provide a service specifically for the support of people with disability?

- ☐ Yes
- ☐ No
- ☐ Don't Know

What kind of support does Additional Provider 3 provide to the person this application is about?

Select all that apply

- ☐ Accommodation (SIL)
- ☐ Accommodation (CSS/OoHC)
- ☐ Accommodation (Respite)
- ☐ Day Support
- ☐ Other

Additional Provider 3 Appointed Program Officer

Additional Provider 3 Appointed Program Officer (APO) Title

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

Additional Provider 3 APO Given Name

Additional Provider 3 APO Family Name

Additional Provider 3 APO Phone No.

The value must be a number

Additional Provider 3 APO Email

Please enter an email

Has the appointment of the Additional Provider 3 APO been approved by the Senior Practitioner?

- ☐ Yes
- ☐ No

What is the Additional Provider 3 APO's ID (this can be found in the APO's approval letter)

The value must be a number

Are there other additional providers? *

You can choose yes if there are more than three additional providers. However, you can only include details of three additional providers in this application. Any other additional providers not included in this application, would need to submit a separate application.

☐ Yes

☐ No

Behaviour Support Plan

Has a Behaviour Support Plan been prepared and attached to this application? *

An application for authorisation of a restrictive practice must be accompanied by a behaviour support plan. The Senior Practitioner cannot authorise the use of a restrictive practice without a behaviour support plan.

☐ Yes

☐ No

If no, please specify why a Behaviour Support Plan is not be submitted with this application *

Behaviour Support Practitioner

Behaviour Support Practitioner Title *

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

Behaviour Support Practitioner Given Name *

Behaviour Support Practitioner Family Name *

Behaviour Support Practitioner Position Title *

Behaviour Practitioner Phone No. *

The value must be a number

Behaviour Support Practitioner Address *

If the person this application is about does not have a current behaviour support practitioner, please explain why not?

The Nature of the Person's Disability

Does the person this application is about have a disability? *

- ☐ Yes
- ☐ No
- ☐ Not Sure

What is the person's main disability *

- ☐ Acquired brain injury
- ☐ Autism
- ☐ Cerebral palsy
- ☐ Developmental delay
- ☐ Down syndrome
- ☐ Global developmental delay
- ☐ Hearing impairment
- ☐ Intellectual disability
- ☐ Multiple sclerosis
- ☐ Other
- ☐ Other neurological
- ☐ Other physical
- ☐ Other sensory/speech
- ☐ Psychosocial disability
- ☐ Spinal cord Injury
- ☐ Stroke
- ☐ Visual impairment

What is the functional impact of the disability on the person? *

Please provide details of the behaviours of concern that are relevant to the proposed use of a restrictive practice. *

Behaviours of concern are behaviours of such frequency, intensity or duration that they put the person or others at risk of physical or other harm

Proposed use of a Restrictive Practice(s)

Please describe the restrictive practice(s) for which authorisation is sought including where and when the restrictive practice(s) will be used.

Are you seeking authorisation to use a Chemical Restraint? *

- ☐ Yes
- ☐ No
- ☐ Not sure

Provide details about the proposed use of a **chemical** restraint *

Are you seeking authorisation to use an Environmental Restraint? *

- ☐ Yes
- ☐ No
- ☐ Not sure

Provide details about proposed use of an **environmental** restraint *

Are you seeking authorisation to use a Mechanical Restraint? *

- ☐ Yes
- ☐ No
- ☐ Not sure

Provide details about proposed use of a **mechanical** restraint *

Are you seeking authorisation to use a Physical Restraint? *

- ☐ Yes
- ☐ No
- ☐ Not sure

Provide details about proposed use of a **physical** restraint *

Are you seeking authorisation to use Seclusion *

- ☐ Yes
- ☐ No
- ☐ Not sure

Provide details about proposed use of **seclusion** *

What is the primary reason for the use of the restrictive practices? *

What are the consequences to the person if the restrictive practice is used? *

What are the consequences to the person, or other persons, if a restrictive practice of that type is not used? *

Are there alternative methods reasonably suitable and able to be used in relation to the person and which responds to the behaviour of concern for which the type of restrictive practice has been proposed? If not, why not? *

What alternative strategies have been tried to manage the behaviour of concern and why they have not been successful? Is the proposed use of a restrictive practice a last resort? *

What is the nature and degree of any significant risks to the person if the restrictive practice is used? *

How does the use of the restrictive practice promote or reduce the safety, health and wellbeing of the person, and to what extent? *

Please describe the plan for reducing and eliminating the use of the restrictive practice(s)? *

About the Application

Has the person this application is about been consulted about this application? *

- ☐ Yes
- ☐ No

Please explain how the person this application is about has or has not been consulted about this application? *

Has the independent person been consulted about this application? *

- ☐ Yes
- ☐ No

Please explain how the independent person has or has not been consulted about this application? *

Has the APO been consulted about this application? *

- ☐ Yes
- ☐ No

Please explain how the APO has or has not been consulted about this application? *

Has the person’s family or support people been consulted about this application? *

- ☐ Yes
- ☐ No

Please explain how the the person’s family or support people have or have not been consulted about this application? *

Who else was consulted about this application? *

Has the person requested the Senior Practitioner to consult with any other person? *

- ☐ Yes
- ☐ No

Provide details about who else the person requested the Senior Practitioner to consult about this application? *

How long are you requesting the authorisation to use a restrictive practice for? *

Note: an authorisation may be in effect for a period of time not exceeding 12 months.

Instructions to Upload Supporting Documents

Once this application is submitted, you will receive an email to upload the supporting documents (including Behavioral Support Plan and other relevant healthcare professional reports and/or relevant incident reports regarding the behaviour of concern - please see the application checklist in the next page for an expanded list of relevant documents).

While you can complete this application on any device (including mobile devices), you may need to use a computer to upload the supporting documents. If you choose to upload documents using a mobile device, click the three dots directly under the "OneDrive" sign at the top left-hand corner of the webpage to access the "Upload" button.

Please ensure your supporting documents are in Word or PDF formats. If your supporting documents include any images, please ensure they are in JPG or PNG formats. The system will not be able to process documents created in other formats.

Please do not make any changes to the documents you have uploaded, as they will be processed immediately after being uploaded. If you need to make any changes, close the window, click the link again and upload the updated version. The system will process the documents accordingly.

If you do not receive a link within 15 minutes of the submission of this application, please send the supporting documents as an attachment in an email to the Office of the Senior Practitioner: seniorpractitioner@dpac.tas.gov.au

Application Checklist

Please ensure you have completed all fields within the form and attached the following documents, if they are relevant to this application.

Incomplete applications **will not** be approved. *

Select all that applies to this application. Please ensure you upload all the relevant documents that you specify below according to the instructions given in the previous page.

- ☐ I will provide any relevant healthcare professional reports.
- ☐ I will provide relevant incident reports regarding the behaviour of concern or the use of a restrictive practice that I would like the Senior Practitioner to consider
- ☐ I will provide other reports relevant to the behaviour of concern or the proposed restrictive practice (e.g. meal management plan, manual handling plan).
- ☐ I will provide the relevant medical reports, medication charts and a copy of the medication purpose form for applications relating to chemical restraint.
- ☐ I will provide the occupational therapy or physiotherapy report prescribing the mechanical restraint for applications relating to mechanical restraint.
- ☐ An application for Appointment of an Independent Person has been or will be submitted

If you would like to provide any additional information regarding attachments to this application, please provide them below

Applicant Declaration

In making and reading through this application, I declare that to the best of my knowledge:

- all information provided in this application is complete, accurate and true
- no details relevant to the application have been left out, and
- the application is not misleading

In submitting this application, I agree that I have given due regard to the *Disability Rights, Inclusion and Safeguarding Act 2024*, specifically:

The principles described in section 8, notably: ** Restrictive practices should only be used in very limited and specific circumstances as a last resort and utilising the least restrictive practice and for the shortest period of time possible in the circumstances; and*

Restrictive practices should only be used where they are proportionate and justified in order to protect the rights or safety of the person with disability or others.

☐ Agree

The regulation of Restricted Practices described in Part 7. ***

☐ Agree

Signature ***

By typing my name below, I acknowledge that I am signing this declaration. This typed name is intended to serve as my signature, signifying my agreement to this declaration

Name ***

Date ***

What happens next?

The APO must make an application to appoint an Independent Person. If you are both the applicant and the APO, you will be prompted in the next section to make the application to appoint an Independent Person. If you are not the APO, the APO will be prompted, via email to make the application to appoint an Independent Person. Once all the material has been received, this application will be assessed by staff from the Office of the Senior Practitioner. As delegates of the Senior Practitioner, staff may choose to conduct interviews, inspect relevant documents or carry out site visits to support the provision of a report to the Senior Practitioner. You will be contacted if further information is required.

The Senior Practitioner may grant, or refuse to grant, authorisation for the use of the restrictive practice for a period of no more than 12 months. The authorisation may also be subject to conditions or limitations. You will be provided with written notice of the Senior Practitioner’s decision, including reasons for the decision. The person the application is about and any person nominated by them will also be notified of the decision.

Attachment A - Application for Appointment of an Independent Person

This application is for an Appointed Program Officer (APO) of a disability services provider (provider) to apply to the Senior Practitioner for the proposed appointment of an Independent Person as defined under the *Disability, Rights, Inclusion and Safeguarding Act 2024* (the Act).

The Independent Person has an important role in ensuring the human rights of the person with disability are protected and is ideally a person known to the person with disability and who has a significant interest in their wellbeing.

An application for approval of a restrictive practice cannot be authorised unless an Independent Person has been approved by the Senior Practitioner. The Senior Practitioner may approve or refuse to approve the appointment of an Independent Person. An approval may also be subject to conditions or limitations as the Senior Practitioner considers appropriate.

If the APO is unable to identify a suitable person to be appointed as an Independent Person, the APO must advise the Senior Practitioner, and the Senior Practitioner will appoint a suitable person.

If the APO or the provider does not agree with the decision of the Senior Practitioner, they can ask for a review. In the first instance, reviews will be undertaken by the Office of the Senior Practitioner. If the provider is not satisfied with the outcome of the review, they can lodge an application for review with the Tasmanian Civil and Administrative Tribunal (TASCAT). This application should be submitted when an application for the authorisation to use a restrictive practice form is submitted.

Is the person making this application the APO? *

- ☐ Yes
- ☐ No

Application for Appointment of an Independent Person

The APO must complete the Application for Appointment of an Independent Person. An email will be sent out to the APO nominated in this application which will include a link to complete the Application for Appointment of an Independent Person separately.

Details of the Proposed Independent Person

Has a suitable person been identified to be the Independent Person? *

- ☐ No
- ☐ Yes

Please explain if you have not identified a suitable person to be the Independent Person *

Independent Person Title *

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mx
- ☐ Other

Independent Person Given Name *

Independent Person Family Name *

Independent Person Phone No. *

The value must be a number

Independent Person Email

Please enter an email

Independent Person Address

Has the proposed Independent Person consented to the Office of the Senior Practitioner contacting them to discuss this application? *

- ☐ Yes
- ☐ No

Suitability of the proposed appointment

What is the relationship of the proposed Independent Person to the person with disability? *

Has the person with disability’s will and preference been taken into account when determining the suitability of the proposed Independent Person? *

- ☐ Yes
- ☐ No

Please explain *

Is the proposed Independent Person willing and able to explain to the person with disability: *

(i) the proposed use of a restrictive practice

- ☐ Yes
- ☐ No
- ☐ Maybe

Please explain *

Is the proposed Independent Person willing and able to explain to the person with disability: *

(ii) that thy seek a review of the Senior Practitioner’s decision to authorise the use of a restrictive practice

- ☐ Yes
- ☐ No
- ☐ Maybe

Please explain *

Is the proposed Independent Person willing and able to support the person with disability to express their will and preference in relation to the proposed use of a restrictive practice? *

- ☐ Yes
- ☐ No
- ☐ Maybe

Please explain *

Is the proposed Independent Person an employee of, a member of the governing body of, or someone who has an interest in a disability services provider for the person with disability? *

- ☐ Yes
- ☐ No

Is the proposed Independent Person a person with responsibility for the development or review of the behaviour support plan for the person with disability? *

- ☐ Yes
- ☐ No

Declaration from the Appointed Program Officer

In submitting this application, I agree that I have given due regard to the *Disability Rights, Inclusion and Safeguarding Act 2024*, specifically section 66 - *Appointment of independent persons*. *

☐ Agree

APO Signature for AIP Declaration *

By typing my name below, I acknowledge that I am signing this declaration. This typed name is intended to serve as my signature, signifying my agreement to this declaration

APO Name for AIP Declaration *

APO Declaration Date *

Privacy Collection Notice and Consent

Purpose of Collection:

We are collecting your personal information (including service provider details, names, contact details, and any other information you provide) for the following purposes: To process this application for authorisation to use a restrictive practice (and if applicable, the application for appointment of an independent person).

Relevant Legislation:

We collect, use and disclose your personal information under the *Disability Rights, Inclusion and Safeguarding Act 2024* and the *Personal Information Protection Act 2004 (TAS)*.

Disclosure of Personal Information:

We may disclose your personal information to the following parties: Tasmanian Government and related entities. This disclosure is necessary for processing your application, legal compliance, and research and statistical purposes.

Your Rights:

You have the right to access and correct your personal information. You can also withdraw your consent at any time before the application is processed.

You can do this by contacting the Office of the Senior Practitioner: seniorpractitioner@dpac.tas.gov.au

If you choose to withdraw your consent, we will not be able to process your application.

Consent *

By submitting this application electronically, I acknowledge that I have read and understood this Privacy Collection Notice and Consent, and I consent to the collection, use, and disclosure of my personal information as described above.

☐ I consent

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