Request for Independent Practitioner, Quality Assurance Panel, Authorisation of Restrictive Practices

Organisation Name	
Name of person making request	
Position	
Phone number	
Email	
Proposed location of Panel	Online / In person (Town/Suburb: ________________________________)
Name of Independent Practitioner requested (if applicable)	
Specialist experience required in Practitioner	☐ Aboriginal and Torres Strait Islanders ☐ CALD ☐ People in regional and remote areas ☐ People with complex communication access needs ☐ People with autism ☐ People with acquired brain injury ☐ People with intellectual disability ☐ People with psychosocial disability
Date of Request	