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| **Instructions for the nurse/ midwife to be supervised** |
| Please read the notification document carefully. **Please complete and sign the document and return to Nursing and Midwifery Council of New South Wales, Locked Bag 20 HAYMARKET NSW 1238.**  It is recommended that you keep a copy of the signed document for your records. By completing and signing this document you are acknowledging that you;* have provided true and accurate information about your CDT supervisor; and
* have provided the Nursing and Midwifery Council of NSW CDT policy to the supervisor.

**It is your responsibility to ensure this form is returned to the Council within the timeframe specified in the original correspondence from the Council.** |
| Full Name |  |
| AHPRA Registration Number |  |

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| --- | --- | --- | --- |
| **SIGN HERE** |  |  |  |
| **Registrant’s signature** |  | **PRINT name and date** |

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| **Instructions for Supervisor** |
| By signing this document as CDT supervisor you are indicating that you have been provided with the Nursing and Midwifery Council’s policy for CDT testing and are able to meet the requirements for CDT supervisors as described in the policy. |

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| **SIGN HERE** |  |  |  |
| **CDT supervisor’s signature** |  | **PRINT name and date** |

**CDT Supervisor Details:**

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| --- | --- |
| Name of organisation: |  |
| Name of supervisor: |  |
| Postal address of organisation: |  |

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| --- | --- |
| Name of pathology provider providing CDT analysis:(e.g. Concord Hospital or alternative provider) |  |
|  |  |  |  |
| Telephone: |  | Fax: |  |
| Email:  |  |