gpmhsc
General Practice Mental Health Standards Collaboration

Application to register as a GP provider of Focussed Psychological Strategies with Medicare Australia

Please complete all sections on this form

Section 1 General information

RACGP/ACRRM number (if applicable)

Provider number

Full name

Date of birth

Preferred mailing address

Suburb

Postcode

Is this your Practice address Home address Other

Business phone

Business fax

Mobile (optional)

Email

Section 2 GPMHSC accredited mental health training

Step 1 Completion of GPMHSC accredited Mental Health Skills Training (MHST)

Please indicate the type of training pathway completed

Primary pathway *(Minimum total of 6 hours of structured interactive learning activity)*

Modular pathway Core Module *(prerequisite)* and Clinical Enhancement Module *(Minimum total of 7 hours of structured interactive learning activities)*

Training provider	Course title	Activity number	Date of completion	Certificate attached

RACGP Royal Australian College of General Practitioners

Australian College of Rural & Remote Medicine WORLD LEADERS IN RURAL PRACTICE

APS Australian Psychological Society

Mental Health Australia

The Royal Australian & New Zealand College of Psychiatrists

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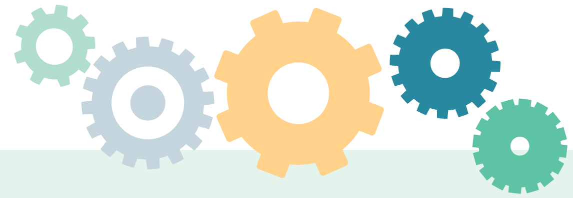

Section 2 GPMHSC accredited mental health training continued

Step 2 Completion of GPMHSC accredited Focussed Psychological Strategies Skills Training (FPS ST)

Training provider	Course title	Activity number	Date of completion	Certificate attached

Section 3 Consent to disclosure of personal information and confirmation of application

I consent to the information provided on this form being used by the GPMHSC to assess whether I have completed appropriate education and training for FPS ST. I understand that the outcome of this assessment and the information collected on this form will be disclosed to Medicare Australia which maintains a register of practitioners who are eligible to access specific mental health Medicare Benefits Schedule (MBS) item numbers.

I also understand that this information may be disclosed to the Commonwealth Department of Health.

I confirm that I wish to apply to be a registered provider of FPS ST, and confirm that I have reviewed and am familiar with the requirements for provision of these services as detailed in the MBS.

I consent that as part of my ongoing requirements as a GP provider of FPS, I need to successfully complete at least one FPS CPD activity each triennium.

Signature Date

Please return this completed and signed form to the GPMHSC Secretariat:

Email **gpmhsc@racgp.org.au** Phone **03 8699 0556** Fax **03 8699 0570**

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