Renewal application for approval as an accredited vocational rehabilitation provider

Introduction

This application must be lodged by providers applying to renew their approval as an accredited vocational rehabilitation provider under Section 50 of the *Return to Work Act 1986* (the Act). If an application is not submitted by 1 April of the third year, the provider's approval will cease at the end of the three-year approval period, being 30 June of the third year.

An organisation wishing to apply for approval should refer to the NT WorkSafe: *Guidelines for approval as an accredited vocational rehabilitation provider (*the Guidelines) and the Head of Workers' Compensation Authorities: *Principles of Practice for Workplace Rehabilitation Providers* (Principles of Practice) prior to making an application.

APPLICATION CHECKLIST

Please ensure you have completed the following sections:

PART A: Business ownership details including association or connection with other organisations which supply services within the workers compensation industry	☐
PART B: Documentation demonstrating conformance with the *Conditions of Approval, including:* ☐ Most recent self-evaluation results ☐ Number of vocational rehabilitation services conducted in each 12 month period ☐ Return to work rates ☐ Three case examples for each 12 month period within the three year approval period	☐
PART C: A signed *Statement of Commitment to the Conditions of Approval for Workplace Rehabilitation Providers*	☐
PART D: A signed *Statement of Commitment to the Principles of Practice for Workplace Rehabilitation Providers*	☐
PART E: A signed consent for NT WorkSafe to liaise with other authorities, where the provider delivers workplace rehabilitation services, to exchange information about the application	☐
PART F: A signed *Declaration of Conformance Workplace Rehabilitation Provider Self-Evaluation*	☐
APPENDIX 1: Current Northern Territory staff details completed for each site, where workplace rehabilitation services intend to be delivered (one sheet per site)	☐

PART A: APPLICANT DETAILS

Organisation details

Full name of organisation:					
Trading name of organisation:					
Nature of organisation:	Company	☐	Partnership		☐
	Sole Trader	☐	Individual subsidiary of a government body		☐
Name of principal(s):					
ABN (for Australian business only):			ACN (if applicable):		
Daytime contact number:			Mobile number:		
Email address:			Fax number:		
Organisation street address (must NOT be a PO Box)					
Unit number/Street number/Property number:					
Street name:					
Suburb:		State:		Postcode:	
Postal address					
☐ Same as organisation street address (as above)					
Unit number/Street number/Property number:					
Street name:					
Suburb:		State:		Postcode:	

Northern Territory business location

To deliver vocational rehabilitation services in the Northern Territory, you must have a current business address in the Northern Territory. Evidence will be required, such as a current rental agreement.

Field			
Full name of organisation:			
Trading name of organisation:			
Nature of organisation:	Company ☐	Partnership ☐	
	Sole Trader ☐	Individual subsidiary of a government body ☐	
Name of principal(s):			
ABN (for Australian business only):		ACN (if applicable):	
Daytime contact number:		Mobile number:	
Email address:		Fax number:	
Organisation street address (must NOT be a PO Box)			
Evidence provided:	Rental agreement ☐	Other (specify): ☐	
Unit number/Street number/Property number:			
Street name:			
Suburb:	State:	Postcode:	

Application contact person

Field			
Name:		Title:	
Daytime contact number:		Mobile number:	
Email address:			

Other workers compensation authorities where approval has been granted

Please attach evidence of any other approval granted (if applicable).

NSW ☐	VIC ☐	QLD ☐	WA ☐
SA ☐	ACT ☐	TAS ☐	COMCARE ☐

Previous applications

Has an Australian workers compensation jurisdiction refused or withdrawn approval of the organisation, owner(s) and/or management and/or any persons employed or engaged to deliver workplace rehabilitation services?	
Yes ☐	No ☐
If **yes**, please provide details below.	

Conflict of interest

Refer to *Principles of Practice for Workplace Rehabilitation Providers – Appendix B*

Has a conflict of interest been identified with other suppliers of services within any workers compensation authority in the current approval period?	
Yes ☐	No ☐
If **yes**, please provide details and how it was managed.	
Detail all of your organisation's business affiliations with other suppliers of service within any of the workers compensation authority.	

Professional misconduct or criminal proceedings

Are there any proceedings that have been taken (or are pending) against the organisation, owner/s and /or management, and/or any person employed or engaged to deliver workplace rehabilitation services, in relation to professional misconduct or criminal proceedings, breaches of the privacy act or financial administration acts?			
Yes	☐	No	☐
If **yes**, provide details of the circumstances and reasons why there is no cause to reject your organisation's application for renewal.			

Insurance currency

In the context of workplace rehabilitation service provision, please attach copies of your organisation's:			
Professional Indemnity Insurance			
Please detail:			
Policy number:		Expiry date (DD/MM/YYYY):	
Public Liability Insurance			
Please detail:			
Policy number:		Expiry date (DD/MM/YYYY):	
Northern Territory Workers Compensation Insurance			
Please detail:			
Policy number:		Expiry date (DD/MM/YYYY):	

Please note: If delivering services in the Northern Territory, you must hold a current workers compensation insurance policy provided by an approved insurer in the Northern Territory.

Please follow the link below for information on obtaining a Northern Territory workers compensation insurance policy.

https://worksafe.nt.gov.au/workers-compensation/insurers

PART B: CONFORMING TO THE *CONDITIONS OF APPROVAL*

Condition 1: Statement of Commitment to the Conditions of Approval for Workplace Rehabilitation Providers (PART C)

Please provide a signed *Statement of Commitment to the Conditions of Approval for Workplace Rehabilitation Providers*.

Attached: Yes ☐ **No** ☐

Condition 2: Evidence of a staff member's current Northern Territory residency

Please refer to 'Appendix 1 – Staff Details' for a list of what documentation you can provide as evidence.

Attached: Yes ☐ **No** ☐

Condition 3: Staff (Appendix 1)

Please provide current staff details for each site where workplace rehabilitation services may be delivered.

Attached: Yes ☐ **No** ☐

Condition 4: Person(s) in management structure able to demonstrate at least five years relevant workplace rehabilitation experience

Name:	Title:
Daytime contact number:	Mobile number:
Email address:	
Name:	Title:
Daytime contact number:	Mobile number:
Email address:	

Please provide evidence of the person(s) relevant rehabilitation consultant qualification as outlined in the *Principles of Practice for Workplace Rehabilitation Providers*.

Attached: Yes ☐ No ☐

Condition 5: Provider annual self-evaluation (PART F)

Provide a signed *Declaration of Conformance Workplace Rehabilitation Provider Self-Evaluation* to the *Conditions of Approval* from your organisation's most recent annual self-evaluation, noting whether you achieved Level 1 conformance (95%), level 2 (85%) or a non-conformance (<85%) rating.

Please provide a copy of any quality improvement plan implemented to address the identified non-conformities.

Attached: Yes ☐ No ☐

Condition 6: Cases of workplace rehabilitation activity

Please attach case data to demonstrate management of three cases (excludes assessment only cases) of activity consistent with the model of vocational rehabilitation for injured workers within the Northern Territory for each 12 month period within your approval period. (Due consideration will be given to organisations servicing remote areas).

Attached: Yes ☐ No ☐

Condition 7: Minimum return to work rates

Please refer to the NT WorkSafe: *Guidelines for approval as an accredited vocational rehabilitation provider,* Appendix 3 – return to work rates spreadsheet.

Please complete the spreadsheet for each year of the current approval period.

Attached: Yes ☐ No ☐

Condition 8: Statement of commitment to the Principles of Practice for Workplace Rehabilitation Providers (Part D)

Please provide a signed *Statement of commitment to the Principles of Practice for Workplace Rehabilitation Providers.*

Attached: Yes ☐ No ☐

Condition 9: Safe environment

Please provide a copy of your latest OH&S audit.

Attached: Yes ☐ No ☐

Condition 10: Financial Solvency

Please provide evidence of your most recent ratified actuary/financial audit

Attached: Yes ☐ No ☐

PART C: STATEMENT OF COMMITMENT TO THE CONDITIONS OF APPROVAL CRITERIA

Read and sign the below statement acknowledging commitment to the Approval Criteria and Conditions of Approval.

The Approval Criteria and Conditions of Approval:

1. The vocational rehabilitation provider must comply with the *Conditions of Approval*, along with the contents of the Principles of Practice and the Guidelines generally, as ongoing requirements.
2. The vocational rehabilitation provider must have at least one worker who is a Northern Territory resident.
3. The vocational rehabilitation provider must ensure that all services are delivered in accordance with the workplace rehabilitation model by persons who hold the minimum qualifications as defined in the *Principles of Practice* and the Guidelines.
4. The vocational rehabilitation provider's management structure must include at least one person who holds a rehabilitation consultant qualification outlined in the *Principles of Practice for Workplace Rehabilitation Providers,* and who is able to demonstrate five years' relevant vocational rehabilitation experience.
5. The vocational rehabilitation provider must participate in annual self-evaluations and independent evaluations as required by NT WorkSafe to demonstrate conformance with the *Approval Criteria* and *Conditions of Approval*.
6. An organisation must demonstrate management of 3 cases (excludes assessment only cases) of workplace rehabilitation for each 12 month period within the three year approval period (if 3 cases from the Northern Territory are not available, it can be made up from other jurisdictions where you are approved). Due consideration will be given to organisations servicing rural and remote areas).
7. NT WorkSafe does not set a minimum return to work rate, however NT WorkSafe will require annual reporting on return to work rates in the format provided in Appendix 3 of the Guidelines.
8. The vocational rehabilitation provider must deliver services in compliance with the *Principles of Practice for Workplace Rehabilitation Providers* and the *Guidelines.*
9. The vocational rehabilitation provider's facilities at all locations where services are delivered must provide an accessible and appropriate environment for workers, staff and visitors and comply with local workplace health and safety legislation.
10. The vocational rehabilitation provider must remain financially solvent.
11. The vocational rehabilitation provider must notify NT WorkSafe in advance, in writing, or as soon as practical, if any of the following situations arise and accept that NT WorkSafe will review the status of approval and determine whether the proposed arrangements conform with the *Approval Criteria* and *Conditions of Approval*:
    i. the business is sold or the controlling interest in the business is taken over by a new shareholder(s), owner(s) or director(s)
    ii. the business changes its trading name or location of premises
    iii. the business supplies or has connections with other suppliers of services within the workers compensation industry
    iv. a new chief executive officer or director or head of management is appointed
    v. there is a major change in the service delivery model and/or staff which may impact on the delivery of the workplace rehabilitation services
    vi. any change in NT staff delivering rehabilitation services (new staff will require endorsement from NT WorkSafe prior to delivering services)
    vii. there is any other change that affects, or may affect, the provider's service quality and procedures
    viii. the provider has entered into voluntary financial administration, becomes insolvent or is the subject of bankruptcy proceedings
    ix. there is any professional misconduct proceedings being taken against the provider or any individuals employed or engaged by the provider.
12. The vocational rehabilitation provider must accept that NT WorkSafe may:
    i. initiate an evaluation at any time during the period of the approval, which may involve an evaluation of conformance to the *Approval Criteria* or *Conditions of Approval*.

ii. consult with the relevant professional or industry associations in determining what are reasonable expectations regarding performance

iii. impose additional requirements

iv. exchange information with other workers compensation authorities on provider performance

v. cancel approval status if the above conditions are not met

NT WorkSafe reserves the right to request evidence of supervision where required, of a person delivering services (refer to NEW application – Principle 6 “competent and qualified professionals”)

I/We have read, understand and accept that I/we must meet and continue to conform to the *Approval Criteria* and *Conditions of Approval* and give consent for sharing of information in relation to this application and the ongoing approval.

I/We understand and are aware that any breach with the terms and conditions of the *Approval Criteria* or *Conditions of Approval* or *Principles of Practice* or *Guidelines* generally may nullify any application or *Instrument of Approval* issued by the Work Health Authority in the event the application is approved.

To be signed by the person/s who is/are authorised to sign this application on behalf of the organisation seeking approval as a workplace rehabilitation provider.

Organisation name:		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		

PART D: STATEMENT OF COMMITMENT TO THE PRINCIPLES OF PRACTICE FOR VOCATIONAL REHABILITATION PROVIDERS

Please refer to the Head of Workers' Compensation Authorities: *Principles of Practice for Workplace Rehabilitation Providers.*

I/We have read and agree to conform to the *Principles of Practice for Workplace Rehabilitation Providers* if approved as a vocational rehabilitation provider.

I/We understand and are aware that any breach of the *Principles of Practice for Workplace Rehabilitation Providers* may nullify any accreditation issued by the Work Health Authority in the event the application is approved.

To be signed by the person(s) who is/are authorised to sign this application on behalf of the organisation seeking approval as a workplace rehabilitation provider.

Organisation name:		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		

PART E: CONSENT TO COLLECT, DISCLOSE AND RELEASE INFORMATION

NT WorkSafe reserves the right to liaise with other workers compensation authorities, where the provider delivers workplace rehabilitation services, to exchange information about the application.

I/We consent to the collection, disclosure and release of information with other jurisdictional workers compensation authorities.

To be signed by the person(s) who is/are authorised to sign this application on behalf of the organisation seeking approval as a workplace rehabilitation provider.

Organisation name:		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		

PART F: DECLARATION OF CONFORMANCE WORKPLACE REHABILITATION PROVIDER SELF-EVALUATION

Our organisation is conforming to the Conditions of Approval for vocational rehabilitation providers within the workers compensation system.	
Yes ☐	No ☐
If **no**, please detail the Condition(s) to which your organisation did not comply and the corrective actions to address the non-compliance(s) (this information can be in the form of an attachment)	
Person(s) who conducted the evaluation:	

On behalf of the organisation, the principals head(s) declare:

The person(s) who conducted the evaluation meet the requirements of an evaluator.	
Yes ☐	No ☐
If **no**, please outline the persons qualifications	
The person(s) who conducted the evaluation was/were not personally responsible for the aspects of the business that they evaluated.	
Yes ☐	No ☐
If **no**, please provide details	
On behalf of the organisation, the principal head(s) acknowledges and accepts the consequences of making a false declaration.	
Yes ☐	No ☐

To be signed by the principle head(s)

Organisation name:		
Name of authorised signatory:		
Title of authorised signatory:		
Signature of authorised signatory:		
Date		

APPENDIX 1: STAFF DETAILS

- This form must be completed as part of your application for all vocational rehabilitation providers delivering prescribed workplace rehabilitation services for your organisation, in accordance with the Act
- Include information on which workplace rehabilitation services are being delivered by each staff member and the location at which the services are delivered
- For multi jurisdiction organisations, vocational rehabilitation providers who reside outside the Northern Territory, however visit the Territory to deliver workplace rehabilitation services under the Act, should also be included on this form
- Duplicate the table provided if necessary to list all staff members, services delivered and locations from which services are delivered

Please ensure the information below is completed for your organisation:

Organisation name:		ABN:	
Location address:		Postal address:	
Accreditation number:		Details as at date:	
Contact name:		Contact position title:	
Email address:		Telephone number:	
Mobile number:		Facsimile number:	

Organisations applying to deliver vocational rehabilitation services in the Northern Territory must have at least one worker who is a Northern Territory resident. One of the following would be sufficient to show evidence of a staff member's current NT residential address:

- contract of purchase, current lease or rental document, receipt from an accommodation house or caravan park showing your residential address
- formal NT Government correspondence identifying you and your residential address dated within the last 12 months
- formal Australian Government correspondence identifying you and your residential address dated within the last 12 months
- council rate notice identifying you and your residential address
- financial institution document identifying you and your residential address dated within the last three months
- gas, electricity, water, telephone, pay TV, Foxtel, internet account identifying you and your residential address dated within the last three months
- Australian Taxation Office assessment showing current residential address

Evidence of a staff member's current Northern Territory residential address attached	☐

STAFF DETAILS *continued*

Full name:	
Positon:	
Email:	
Address:	
Location from which services delivered:	
Years of relevant vocation rehabilitation experience:	
Supervision arrangements (for staff with less than 12 months experience):	
Employment type (e.g. full-time, part-time, casual):	
Qualification, including institution and year attained:	
Years of relevant vocation rehabilitation experience:	
Professional membership or registration (type and member number number):	
Type of evidence provided showing staff member's current NT residential address:	

PRESCRIBED WORKPLACE REHABILITATION SERVICES DELIVERED

☐	Initial workplace rehabilitation assessment	☐	Rehabilitation counselling
☐	Assessment of the functional capacity of a worker	☐	Vocational assessment
☐	Workplace assessment	☐	Advice or assistance in relation to job seeking
☐	Job analysis	☐	Advice or assistance in arranging vocational re-education or retraining
☐	Advice concerning job modification	☐	Other:

***Duplicate this page and table as necessary to list all staff members**

OFFICE USE ONLY

Received via:	Mail ☐	Email ☐	Counter ☐	Fax ☐
Date received:			File reference:	
Processed by:			Authorised by:	
Approval issued:	Yes ☐	No ☐	Date of issue:	

Application requirements

PART A – Applicant details		
All sections completed	Yes ☐	No ☐

Attached supporting documents

Evidence of Northern Territory business location	Yes ☐	No ☐
Evidence of approval from any other workers compensation authorities	Yes ☐	No ☐
Professional Indemnity Insurance policy	Yes ☐	No ☐
Public Liability Insurance policy	Yes ☐	No ☐
NT Workers Compensation Insurance policy	Yes ☐	No ☐

PART B – Conforming to the conditions of approval		
All sections completed	Yes ☐	No ☐

Attached supporting documents

Evidence of a staff members current NT residential address	Yes ☐	No ☐
APPENDIX 1 – Completed staff details sheet	Yes ☐	No ☐
Evidence of relevant rehabilitation consultant qualification	Yes ☐	No ☐
Case data for each 12 month period within three year approval period	Yes ☐	No ☐
APPENDIX 3 – Return to work rates spreadsheet	Yes ☐	No ☐
Latest OH&S audit	Yes ☐	No ☐
Latest actuary/financial audit	Yes ☐	No ☐

PART C – Statement of commitment to the conditions of approval criteria		
Section completed and signed by authorised person	Yes ☐	No ☐

PART D – Statement of commitment to the principles of practice for workplace rehabilitation providers		
Section completed and signed by authorised person	Yes ☐	No ☐

PART E – Consent to collect, disclose and release information		
Section completed and signed by authorised person	Yes ☐	No ☐

PART F – Declaration of conformance workplace rehabilitation provider self-evaluation		
Section completed and signed by authorised person	Yes ☐	No ☐