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Confirmation of Training Position for the Graduate Diploma in Medical Ultrasound Student

The following confirmation form is to be completed by the **site manager or authorised employee.**

☐ I acknowledge that the student/trainee must be actively scanning for a minimum of **three full days per week under direct on-site supervision** with an appropriate student-to-supervisor ratio**.**

☐ I confirm that the student/trainee named below has been approved to undertake their ultrasound clinical training at the site listed below, under the supervision of an ASAR Accredited Medical Sonographer (AMS) with a minimum of **3 years' post accreditation clinical experience in the relevant area of practice**.

OR

☐ I confirm that the student/trainee named below has been approved to undertake **a component** of their ultrasound training at the site listed below, under the supervision of an ASAR Accredited Medical Sonographer with a minimum of three year's experience.

This training position is:

☐ Paid - Please indicate if there is a contract_____

OR

☐ Unpaid – Please indicate if there is a contract_____

OR

☐ Other, please outline_____

I confirm that:

☐ The student/trainee is covered by the following insurance: Public Liability Insurance, Workers Compensation Cover as required by statute, and Professional/Medical Indemnity.

☐ I can provide the student/trainee with copies of Certificates of Currency for the above insurances.

OR

☐ I cannot provide the student/trainee with copies of Certificates of Currency for the above insurances.

☐ I acknowledge that the University of Canberra does not provide the Clinical Training Position and therefore does not cover any insurance for the student undertaking training at this site.

☐ I understand that this is a statement of support and does not obligate the organisation to provide ongoing employment.

☐ I confirm that the student/trainee named below has permission to use de-identified images and other relevant de-identified data for the purpose of student assessment.

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☐ I understand that the supervising sonographer may be requested to undertake clinical skills assessment of the student/trainee from time to time, including meeting in person or online with University of Canberra staff.

☐ I confirm that University of Canberra staff will be permitted to access the site for the purposes of student/trainee assessment or supervision from time to time.

☐ I can confirm that there are no registration restrictions or disciplinary findings that would reasonably impair supervision capacity on the principal supervisor or any other sonographer supervisor.

☐ I confirm there are no conflicts of interest with respect to supervising this student.

OR

☐ I declare a conflict of interest with respect to supervising this student_____

Student Name:	
Site Manager / Authorised employee Name:	
Position:	
Signature:	
Date:	
Clinical Site Name:	
Clinical Site Address:	
Site telephone contact details:	
Email address:	
Accredited Medical Sonographer (AMS), or suitably qualified and experienced medical practitioner. **PRINCIPAL Supervisor name (if different from above site manager name):**	
ASAR AMS Number (Or other registration number, eg AHPRA):	