**Request Form for Mandatory Training Resource Equivalency**

|  |  |  |  |
| --- | --- | --- | --- |
| **Organisation** |  | | |
| **Contact Name** |  | | |
| **Email** |  | | |
| **Telephone Contact** |  | | |
| **Local training resource** | Code: | Duration: | Frequency: |
| Course Name: | | |
| **Equivalency Request matched to**  (Name of State endorsed Mandatory Training Resource) | Code: | Duration: | Frequency: |
| Course Name: | | |

**Document Check List**

|  |  |
| --- | --- |
| **Have you included the *Statement of Learning Objectives/Outcomes*?** | **Yes  No** |
| **Have you reviewed and mapped the Equivalent Training Resources learning Objectives/Outcomes against the State Endorsed Mandatory Training Course Objectives/Outcomes?** | **☐ Yes ☐ No** |
| **Have you included the *Lesson Plan/Instructor’s Guide* for face-to-face sessions?** | **Yes  No** |
| **Have you included a copy of the *Local Training Resources including presentation and handouts*?** | **Yes  No** |

**Authorisation to submit for Equivalency Matching**

|  |
| --- |
| **Chief Executive (or delegate) Authorisation**  **Name:**  **Signature: Date:** |

Return completed Cover Sheet with supporting evidence **via email** to:

[Adele.Zaylaa@health.nsw.gov.au](mailto:Adele.Zaylaa@health.nsw.gov.au) | Program Officer | Professional Practice and Interprofessional Collaboration Directorate | HETI

**Equivalency Mapping Form**

**LHD/SHN/Other Health Agency name:**

**Evidence Submitted:**

**Date:**

| Equivalent Training Resources for Matching | State Endorsed Mandatory Training Course | Equivalency Matched (Yes/No) – Comments (To be completed by panel) |
| --- | --- | --- |
| Title  Duration:  Frequency:  Key Objectives:  Learning Outcomes:  At the end of the module, the learner should be able to: | **Title**  **Duration:**  **Frequency:**  **Key Objectives:**  **Learning Outcomes:**  At the end of the module, the learner should be able to: | Comments: |