**ANNEXURE A1 APPLICATION FOR ACCREDITATION – MEDICAL PRACTITIONER OR DENTIST (INCLUDING SURGICAL ASSISTANT - MEDICAL) AT [INSERT FACILITY NAME]**

|  |
| --- |
| **Application for Accreditation as a Medical Practitioner** **(including Surgical Assistant – Medical) or Dentist** |
| *Please submit your completed application form with the documentation requested in the sections following to the Chief Executive Officer at [INSERT FACILITY NAME]* |
| ❑ **New Appointment**  ❑ **Reappointment** |
| ***For Reappointment:****If this is an application for reappointment and there are no changes to the information required in this application you will only be required to tick the box below, sign and complete your contact details on this application.*❑ This is an application for my reappointment and there are no changes to the information required in the Application for Accreditation since I last applied at [INSERT FACILITY NAME/S]*Signature of Medical Practitioner* *Date* |
| **IF YOU WOULD LIKE TO APPLY FOR ACCREDITATION AT ANY OTHER NEW SOUTH WALES FACILITIES, PLEASE INDICATE BELOW** |
| ❑ | Bega Valley Private Hospital | ❑ | Brisbane Waters Private Hospital | ❑ | Dubbo Private Hospital |
| ❑ | Forster Private Hospital | ❑ | Gosford Private Hospital | ❑ | Healthwoods Day Surgery |
| ❑ | Hurstville Private Hospital | ❑ | Lingard Private Hospital | ❑ | Maitland Private Hospital |
|  ❑ | Mayo Private Hospital | ❑ | Shellharbour Private Hospital | ❑ | South Coast Private Hospital |
|  ❑ | The Hills Clinic | ❑ | Toronto Private Hospital | ❑ | Westmead Rehabilitation Hosp. |
|  ❑ | Wollongong Day Surgery |  |  |  |  |
| **Section 1: Personal Details** |
| Title: *(A/Prof, Dr, Mr, Prof)* |  |
| Surname of Applicant: |  |
| First Names in full: |  |
| Any Former Name Including Maiden Name: |  |
| Date of birth: |  |
| Accreditation category: *(Please refer to page 3 for the criteria category)* |  |
| Partner / Spouse Full Name: *(optional - for invitation purposes only)* |  |
| Provider Number: |  |
| Prescriber Number: |  |
| Emergency Contact Name: |  |
| Emergency Contact Number: |  |
| **Personal Address Details** |
| **Please tick 🗹 your preferred mailing address that is Personal or Practice or Other:** |
| ❑ Residential Address:  |  |
| Suburb: |  | Post Code: |  |
| Home Phone Number: |  | Home Facsimile: |  |
| Mobile Number: |  |
| Email: |  |
| **Practice Address Details (primary):** |
| ❑ Practice Address  |  |
| Suburb: |  | Post Code: |  |
| Practice Telephone: |  | Practice Facsimile: |  |
| Pager Telephone: |  | Pager Number: |  |
| Mobile Number: |  |
| Email Address: |  |
| **Other Address (other consulting rooms etc):** |
| ❑ Other Address |

|  |
| --- |
| **Section 2 Qualifications (*Please attach your Curriculum Vitae and Qualification Documents)*** |
| **Undergraduate qualifications, university and year of graduation:** |
| **Year Obtained:** | **Qualification:** | **Institution:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Postgraduate qualifications, degrees, diplomas, fellowship: *Note: Certified copies of original qualifications should be obtained, if possible*** |
| **Year obtained:** | **Qualification:** | **Authorising Body:** |
|  |  |  |
| Special comments on post graduate experience: |
| **Year obtained:** | **Qualification:** | **Authorising Body:** |
|  |  |  |
| Special comments on post graduate experience: |
| **Year obtained:** | **Qualification:** | **Authorising Body:** |
|  |  |  |
| Special comments on post graduate experience: |

|  |
| --- |
| **Section 3 Appointments:** |
| **Current Appointments:** |
| **Dates:** | **Facility:** | **Appointments:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Previous Appointments (last ten years):** |
| **Dates (From / To):** | **Facility:** | **Appointments:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Itemise Postgraduate Educational Activity in the past three years:** |
|  |
| **Nature of current practice and place of work**  |
|  |
|  |
|  |
| **Publications *(Please attach list or CV): Attached?*** | Yes ❒ | No ❒ |
| **Membership of colleges and/or other relevant Associations *(Please attach list or CV):***  | Yes ❒ | No ❒ |

|  |
| --- |
| **Section 4 Accreditation, Scope of Practice** |
| **Accreditation is sought in the following categories:** |
| ❑ Career / Contracted Medical Officer❑ Consultant Emeritus *(No admitting rights)*❑ Consultant Specialist/General Practitioner *(No admitting rights)*❑ Dental Specialist* Dentist
 | * General Practitioner
* Employed Medical Officer

 *(Resident, Registrar, Career Medical Officer)** Specialist Practitioner
* Staff Specialist
* Surgical Assistant *(No admitting rights)*
 |
| **Accreditation is sought to:** |
| * Admit
* Consult
 | * Diagnostic / Treat
* Assist
 |
| **Specialty In Which Accreditation Is Applied For:** |
| **P** |
| ***Please complete Scope of Practice (page 3) to complete your Specialty (n/a Surgical Assistants)*** |
| Does your scope of practice require the use of: |
| 1) Fluoroscopy / Laser and / or Angiography Equipment | ❑ Yes ❑ No |
| ***If Yes*** *attach the EPA Radiation Licence to this application and note the Radiation User Licence Expiry Date****☞*** |  |
| 2) Laser Equipment | ❑ Yes ❑ No |
| ***If Yes*** *attach the Laser Certification to this application and note the Laser Certificate Expiry Date****☞*** |  |
| **Appointment Period (to be completed by the hospital)** |
| ❑ Temporary ❑ Five Years ❑ Other Term | ------ / ----- / 20-- to ----- / ----- / 20-- |

|  |
| --- |
| **Surgical Assistant applicants only:**Name of accredited practitioner at each applicable hospital who will provide a reference for you. |
| **Name** | **Address & Phone Number** | **Hospital** |
|  |  |  |
| **Name** | **Address & Phone** | **Hospital** |
|  |  |  |
| **Name** | **Address & Phone** | **Hospital** |
|  |  |  |
| **Name** | **Address & Phone** | **Hospital** |
|  |  |  |
| **Name** | **Address & Phone** | **Hospital** |
|  |  |  |
| **Accreditation (Please tick):** |
| ❑ Permanent | ❑ Temporaryfrom \_\_\_\_\_\_\_/\_\_\_\_\_\_/ 20\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_/ 20\_\_\_\_  |

**Clinical privileges are sought in the field(s) of: *(Not applicable to Surgical Assistants)***

* **Anaesthesia**
* Adults
* Cardiac-Adult Only
* Neonatal (<1 year old)
* Obstetrics
* Paediatrics (>1 year old)
* Trans-oesophageal Echocardiography (TOE)-Adults Only
* Chronic Pain
* **Cardiac Perfusion**
* **Cardiology**
* Cardiologists
* TOE
* Procedural Cardiologist
* Diagnostic Angiography
* Interventional Cardiologist
* Angioplasty
* Electro Physiologist
* **Emergency Medicine**
* **Gastroenterology**
* Diagnostic Upper Gastrointestinal Endoscopy
* Therapeutic Upper Gastrointestinal Endoscopy
* Sclerotherapy
* Oesophageal Banding & Placement of Prostheses
* Oesophageal Dilatation
* Flexible Sigmoidoscopy
* Diagnostic Colonoscopy
* Endoscopic Retrograde Cholangiopancreatography (ERCP) & associated Therapeutic Interventions
* Biliary Stenting
* Percutaneous Gastrostomy (PEG)
* **Gynaecology-General**
* Advanced Endoscopic Surgery
* Gynaecology General
* Laparoscopic Surgery
* Prolapse Surgery
* Ultrasound
* Assisted Reproductive Services
* Gynaecological Oncology
* Gynaecology Oncology
* Uro-Gynaecology
* **Intensive Care**
* Adult
* Paediatric

**Medicine**

* **General Medicine**
* Adult
* Paediatric Medicine
* General Medicine
* Neonatology (34 weeks or later)
* Medical Oncology
* Dermatology
* Endocrinology
* Geriatrics
* Hepatology
* Immunology
* Infectious Diseases
* Internal Medicine
* Neurology
* Oncology
* Adult
* Medical Oncology
* Paediatric Oncology
* Radiation Oncology
* Palliative Care
* Haematology
* Rehabilitation
* Renal Medicine
* Nephrology-General
* Nephrology-Interventional
* Renal Dialysis
* Respiratory Medicine
* Bronchoscopy-Diagnostic
* Bronchoscopy-Therapeutic
* Sleep Medicine
* Rheumatology
* Other please specify:
* **Obstetrics**
* Maternal Fetal Medicine
* Ultrasound
* Uro-gynaecology
* **Nuclear Medicine**
* **Occupational Medicine**
* **Pathology**
* **Psychiatry**
* General Adult
* Consultation - Liaison
* Addiction Psychology
* PTSD (EMDR)
* ECT
* TMS
* Eating Disorder
* Psychotherapy
* **Radiology**
* Diagnostic Imaging
* Interventional Radiology
* Cardiac Catheterisation
* Diagnostic *(perform at least 100 procedures per annum)*
* Interventional *(perform at least 75 procedures per annum)*
* Vascular Catheterisation
* Diagnostic
* Interventional

**Surgery**

**❑ Cardiothoracic Surgery**

* Adult Only
* Valvular Procedures
* Coronary Artery Bypass
* Off Pump Procedures
* Minimally Invasive Surgery
* Arrhythmia Surgery
* Thoracic Aorta Procedures
* Thoracic Lung Procedures
* Insertion of Pacemaker
* Paediatric Only

**❑ Other please specify:**



**❑ Dental**

* Adult
* Paediatric

**❑ Dental Specialist**

* Specify:

**❑ ENT Surgery**

* Adult
* Paediatric
* Paediatric Endoscopic
* Adenoidectomy
* Bronchial Procedures
* Ear Procedures
* Facial Nerve
* Laryngeal Procedures
* Otolaryngeal-Head& Neck
* Pharyngeal Procedures
* Tonsillectomy
* Tracheal Procedures
* Other please specify:

❑ **General Surgery**

* Adult
* Colorectal Surgery
* Endocrine Surgery
* Adrenalectomy
* Thyroidectomy
* Endoscopic Surgery
* Gastrointestinal Surgery
* Laparoscopic Surgery
* Diagnostic
* Interventional
* Upper GI Surgery

❑ **General Surgery – sub specialty**

* Paediatric
* Breast Surgery
* Oncoplastic
* Hepatobiliary & Pancreatic Surgery
* Oesophagectomy
* Bariatric – Adults & (16-18yo) only
* Lap Banding
* Modified Roux-en-Y
* Sleeve Gastrectomy

❑ **Neurosurgery**

* Adult
* Paediatric
* Nerve Procedures
* Spinal Procedures
* Cranial Procedures

❑ **Ophthalmology**

* Adult
* Paediatric
* Cataract Surgery
* Corneal transplantation
* Eyelid Surgery
* Glaucoma Surgery
* Lacrimal Surgery
* Oculoplastic
* Orbital Surgery
* Pterygium Surgery
* Refractive Surgery
* Squint Surgery

❑ **Oral and Maxillofacial Surgery**

* Adult
* Paediatric
* Facio-Maxillary Surgery
* Mandibular Osteotomy
* Other please specify:

❑ **Orthopaedics - General**

* Adult
* Paediatric
* Arthroscopy
* Fracture Management
* Major Joint Replacement
* Podiatric Surgery

❑ **Orthopaedics – sub specialty**

* Reconstructive Surgery
* Spinal Surgery

❑ **Paediatric Surgery**

* Other please specify:

❑ **Plastic and Reconstructive Surgery**

* Adult
* Cosmetic Surgery
* Augmentation Mammoplasty
* Abdominoplasty
* Blepharoplasty
* Body Contouring
* Body Lift
* Brachioplasty
* Brow Lift
* Laser Ablation
* Liposuction
* Mastopexy
* Mentoplasty
* Otoplasty
* Rhinoplasty
* Rhytidectomy
* Reconstructive Surgery
* Breast reconstructive surgery
* Burns Surgery
* Facial Reconstruction
* Hand Surgery
* Microsurgery
* Neurovascular Flaps
* Surgery for congenital deformity
* Paediatric
* Bats Ears Only
* Repair Lacerations Only
* Revision of Scars Only
* Other please specify

❑ **Urology - General**

* Adult
* Paediatric
* Endoscopic Urology
* Laparoscopic Urology
* Laser
* Green Light Laser
* Open Urological Procedures
* Other please specify

❑ **Urology – Sub Specialty**

* HiFU
* Lithotripsy

❑ **Vascular Surgery**

* Procedure:
* Anastomosis
* Arterial Patch
* Bypass
* Decompression
* Enbolectomy
* Endarterectomy
* Ligation of Aneurysms
* Repair
* Replacement
* Thrombectomy
* Vascular Trauma of the following:
* Adnominal
* Aortic
* Mesenteric
* Open
* Axillary, Subclavian
* Carotid Surgery – Open
* Endovascular Procedures
* AAA Stent Grafts
* Diagnostic Procedures
* Embolisation Procedures
* Peripheral Interventions
* Renal Stenting
* Femoral
* Lilac
* Jugular
* Renal
* Temporal
* Thoracic

|  |
| --- |
| **Other privileges sought: *(Not applicable to surgical assistants)*** |
| Field | Surgical Admitting | Medical Admitting | Consulting | Other (specify) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Section 5 Referees** **For each speciality in which you are seeking privileges, please provide the names, addresses and contact numbers of three peer referees in Australia who can attest to your recent practice and who are not related to you nor financially linked with or financially dependent on you.*****(Not applicable to surgical assistants)***  |
| Name of Referee 1: |  |
| Specialty: |  |
| Address: |  |
| Contact Number: |  | Email: |  |
| Name of Referee 2: |  |
| Specialty: |  |
| Address: |
| Contact Number: |  | Email: |  |
| Name of Referee 3: |  |
| Specialty: |  |
| Address: |  |
| Contact Number: |  | Email: |  |

|  |
| --- |
| **Section 6 Registration** **Please record your current AHPRA registration number and attach a photocopy of you registration certificate to the application:** |
| State(s): |  | Registration Number: |  | Expiry Date: |  |
| Scope of Clinical Practice: |  |
| 6.1 Do you have any endorsements or notations against your current medical registration? *(circle)* | Yes ❒ | No ❒ |
| If Yes provide details:  |  |
| 6.2 Do you have any conditions, undertakings or reprimands against your current medical registration? *(circle)* | Yes ❒ | No ❒ |
| If Yes, provide details: |  |
| 6.3 As per Healthe Care Australia’s Hospital By-Laws should AHPRA impose any conditions and/or restrictions on my medical registration or should I enter into an agreement with AHPRA about these matters, in the future, I confirm that I will immediately notify the Hospital’s CEO of the nature and extent of such conditions and/or restrictions.  | Yes ❒ | No ❒ |

|  |
| --- |
| **Section 7 Insurance and Disclosure**Please state the name of your Medical Defence Organisation or your Professional Indemnity Insurance Provider and attach a copy of your current Professional Indemnity Insurance Certificate and Schedule to this application.*NB: Accredited Practitioners must hold professional indemnity insurance cover issued by an Australian insurer. All Accredited Practitioners must hold a minimum level of cover of $20 million for each claim and in the aggregate.* Where the Accredited Practitioner will be conducting Clinical Trials or Research this needs to be noted on the policy.Please note it is a requirement to provide a copy yearly upon policy renewal to the Hospital CEO as documentary evidence of the level of this cover and also to immediately advise any material changes to the level of cover or conditions of the policy. |
| Name on Policy: |  | Expiry Date: |  / /20 |
| Policy Number: |  | Insurance Company: |  |
| Category of cover: *(insert specialty e.g. Surgeon – General):* |  |
| Billing less than $ *(insert amount)* *(insert specialty)* |
| 7.1. Does your insurance fully cover the types of privileges you have applied for? | Yes ❒ | No ❒ |
| 7.2. Do you have any conditions imposed by your indemnity insurance provider that you are required to comply with in order to maintain coverage or are there limitations on coverage ? (If so, please provide a copy of the relevant section of your insurance policy) | Yes ❒ | No ❒ |
| 7.3. I consent to Healthe Care Australia contacting my indemnity insurance provider directly, should it desire for any reason, to obtain a full copy of my indemnity insurance policy. *(If yes, please provide the attached signed authority)* | Yes ❒ | No ❒ |
| 7.4. Should my indemnity insurance provider impose any conditions and/or restrictions on my Indemnity insurance policy, in the future, I confirm that I will immediately notify the hospital CEO of the nature and extent of such conditions and/or restrictions. | Yes ❒ | No ❒ |
| 7.5. Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been the subject of internal or external review, reduced, suspended or revoked or have you had conditions attached to that appointment for any reason? | Yes ❒ | No ❒ |
| *If you answered Yes to the above, please provide dates and particulars:* |
|  |
|  |
| 7.6. Have you ever had any restrictions / conditions placed on your Medical Registration or have you ever entered into undertakings with AHPRA or your registration board ? | Yes ❒ | No ❒ |
| *(If you answered Yes to the above, please provide details including details of the restrictions / conditions and period during which the restrictions apply / applied):* |
|  |
|  |
| 7.7 Have you previously been refused accreditation at another health care facility? | Yes ❒ | No ❒ |
| *(If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note: A senior executive of the hospital may contact the facility)* |
|  |
|  |
| 7.8 Has your Scope of Practice or Clinical Privileges been restricted, suspended, not renewed or have you been the subject of adverse or critical findings as part of an internal or external review initiated at any other health care facility? | Yes ❒ | No ❒ |
| (If you answered yes to the above, please provide name of the facility & rationale for refusal / restriction / suspension / recommendation. Please note, a senior executive of the hospital may contact the facility). |
|  |
|  |
| 7.9 Are you currently under investigation or have there ever been any adverse or critical findings made against you which may be relevant to your appointment (for example: with respect to patient management, behaviour, breach of insurance / medical laws, professional misconduct, sexual assaults or assault) by: Health Insurance Commission / Medicare / Professional Services Review, Medical Board / AHPRA, a Health Care Complaints Commission/body, a Coroner, Police, College, a Court or any other professional disciplinary or similar body? | Yes ❒ | No ❒ |
| *(If you answered yes to the above, please provide details)* |
|  |
|  |
| 7.10 Do have any illness or disability which may adversely affect your ability or fitness to practice? | Yes ❒ | No ❒ |
| *(If you answered yes to the above, please provide details)* |
|  |
|  |
| 7.11 Criminal Record Check – have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence, any offence involving dishonesty or drugs, breach of any laws that regulate the provision of health care or health insurance, charged with or convicted of a criminal indictable offence (other than a spent conviction)?  | Yes ❒ | No ❒ |
| *(If you answered yes to the above, please provide details and a copy of your current police check last three (3) months)* |
|  |
|  |
| **7.12 Working with Children – complete if applicable** A Working with Children Check is required of applicants who will be undertaking direct and unsupervised contact with children in the course of their work.  | WWCC Clearance Number: |
| 7.13 Are you likely to be undertaking child related work meeting the definition above?  | Yes ❒ | No ❒ |
| 7.14 If you answered yes to the above question, do you consent to make a prohibited Employment Declaration and a Background Check, as prescribed by the relevant law? | Yes ❒ | No ❒ |
| **Please attach your current Working With Children Clearance Certificate to this application** |
| **Section 8 Emergency Contact**Please nominate a medical practitioner accredited at the Healthe Care Australia Hospital with an equivalent scope of practice where you are seeking accreditation who has agreed to be contacted and deputise for you in the event that you are unavailable. *(NB: Not applicable for Surgical Assistants):* |
| Name: |  |
| Specialty: |  |
| Contact Numbers: | Home: Mob: Pager: |
| Facility: |  |
| **Specialist Directory:***(Not applicable to surgical assistants)* |
| * I authorise the Hospital to include my details in the Hospitals Specialist Directory
 | **Yes** ❒ | **No** ❒ |
| **Authority:** |
| * I hereby apply for accreditation at *[INSERT FACILITY NAME]* for the clinical privileges I have specified and as attached to this application.
 |
| * In making this application I acknowledge and agree that:
* I have received a copy of the Healthe Care Australia Pty Ltd Hospital By-Laws.
* I have read and understood the Healthe Care Australia Pty Ltd Hospital By-Laws.
* If I am appointed I accept all of requirements set out in, and will comply in full with, the Healthe Care Australia Pty Ltd By-Laws, as amended from time to time.
* The Hospital executives, its officers and the medical advisory committee may seek information about my past experience, clinical performance and current fitness.
* If I have provided misleading, deceptive or inaccurate information or information which is likely to mislead, deceive or be inaccurate (including through omission), Healthe Care Australia Pty Ltd may (in its absolute discretion) immediate proceed to suspension or termination of my Accreditation.
* I will immediately notify the CEO of *[INSERT FACILITY NAME]* of any material changes or additional relevant information with respect to the information already provided by me in connection with this application so that it remains accurate while the application is under consideration.
* I will also notify the CEO in any of the following events (but not limited to the following events):
* The relevant statutory professional registration board makes an adverse finding against me or suspends, revokes or places any limitation on my registration;
* I do not have professional indemnity insurance cover in place for any reason;
* I am convicted of a serious criminal offence
* I understand that my Appointment as an Accredited Practitioner, if granted, will be reviewed in 5 years or earlier if considered necessary.
 |
| **Applicant’s Name:** |  |
| **Signature** |  | **Date:** |  |
| **Witness Name:** |  |
| **Signature:** |  | **Date:** |  |