**ANNEXURE A2 APPLICATION FOR ACCREDITATION OF HEALTH PROFESSIONAL (OTHER THAN MEDICAL PRACTITIONER OR DENTIST)**

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| **Application for Accreditation of Health Professional**  **(Other than Medical Practitioner or Dentist)** | | | | | | |
| *Please submit your completed application form with the documentation requested in the sections following to the Chief Executive Officer at Gosford Private Hospital* | | | | | | |
| ❑ **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 Health Professional*  *Date* | | | | | | |
| **IF YOU WOULD LIKE TO APPLY FOR ACCREDITATION AT ANY OTHER NEW SOUTH WALES FACILITIES, PLEASE INDICATE BELOW** | | | | | | |
| ❑ | Brisbane Waters Private Hospital | ❑ | Dubbo Private Hospital | | ❑ | Gosford Private Hospital |
| ❑ | Hurstville Private Hospital | ❑ | Lingard Private Hospital | | ❑ | Maitland Private Hospital |
| ❑ | Mayo Private Hospital | ❑ | Toronto Private Hospital | |  |  |
| **Section 1: Personal Details** | | | | | | |
| Title: | | | |  | | |
| 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)* | | | |  | | |
| Provider Number *(if applicable)*: | | | |  | | |
| Prescriber Number *(if applicable)* | | | |  | | |
| Emergency Contact Name: | | | |  | | |
| Emergency Contact Number: | | | |  | | |

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| **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) if applicable:** | | | | | | | | | | | | | |
| ❑ Practice Address |  | | | | | | | | | | | | |
| Suburb: |  | | | | | | | | Post Code: | | |  | |
| Practice Telephone: |  | | | | Practice Facsimile: | | | | |  | | | |
| Pager Telephone: |  | | | | Pager Number: | | | | |  | | | |
| Mobile Number: |  | | | | | | | | | | | | |
| Email Address: |  | | | | | | | | | | | | |
| **Other Address (other consulting rooms etc) if applicable:** | | | | | | | | | | | | | |
| ❑ Other Address | | | | | | | | | | | | | |
| **Section 2 Qualifications (*Please attach your Curriculum Vitae and Qualification Documents)*** | | | | | | | | | | | | | |
| **Undergraduate qualifications, university and year of graduation:** | | | | | | | | | | | | | |
| **Year Obtained:** | | | **Qualification:** | | | | | **Institution:** | | | | | |
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| **Postgraduate qualifications, degrees, diplomas, fellowship: *Note: Certified copies of original qualifications should be obtained, if possible*** | | | | | | | | | | | | | |
| **Year obtained:** | | | **Qualification:** | | | | | **Authorising Body:** | | | | | |
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| Special comments on post graduate experience: | | | | | | | | | | | | | |
| **Year obtained:** | | | **Qualification:** | | | | | **Authorising Body:** | | | | | |
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| Special comments on post graduate experience: | | | | | | | | | | | | | |
| **Year obtained:** | | **Qualification:** | | | | | | **Authorising Body:** | | | | | |
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| Special comments on post graduate experience: | | | | | | | | | | | | | |
| **Section 3 Appointments:** | | | | | | | | | | | | | |
| **Current Appointments:** | | | | | | | | | | | | | |
| **Dates:** | | **Facility:** | | | | | **Appointments:** | | | | | | |
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| **Previous Appointments / Employment History (last ten years):** | | | | | | | | | | | | | |
| **Dates (From / To):** | | **Facility:** | | | | | **Appointments:** | | | | | | |
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| **Itemise Postgraduate Educational Activity in the past three years:** | | | | | | | | | | | | | |
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| **Nature of current practice and place of work** | | | | | | | | | | | | | |
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| **Publications *(Please attach list or CV if applicable): Attached?*** | | | | | | | | | | | Yes ❒ | | No ❒ |
| **Membership of colleges and/or other relevant Associations *(Please attach list or CV):*** | | | | | | | | | | | Yes ❒ | | No ❒ |
| **Appointment Period (to be completed by the hospital)** | | | | | | | | | | | | | |
| ❑ Temporary ❑ Five Years ❑ Other Term  ------ / ----- / 20-- to ----- / ----- / 20— | | | | | | ❑ Employed  ❑ Full Time ❑ Part Time ❑ Casual | | | | | | | |

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| **Section 4 Accreditation, Scope of Practice** | | |
| **Appointment / employment (as relevant) sought:** | | |
| ❒ Allied Health Professional | ❒ Chiropractor | ❒ Occupational Therapist |
| ❒ Physiotherapist | ❒ Podiatrist | ❒ Psychologist |
| ❒ Speech Therapist | ❒ Social Worker |  |
| ❒ Other: *(please specify)* | | |
| ❒ Independent Midwife (*Please provide details):* | | |
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| ❒ Nurse Practitioner (*Please provide details):* | | |
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| ❒ Perioperative Nurse Surgical Assistant (*Please provide details):* | | |
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| ❒ Registered Nurse employed by credentialed Visiting Medical Officer (*Please provide details: including evidence of VMO insurance covering your practice)* | | |
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| ❒ Other Practitioner (*Please provide details):* | | |
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| Name of accredited practitioner at the hospital who is sponsoring you and with whom you will work? (complete if applicable for the clinical privileges sought) | | |
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| **Section 5 Referees**  **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.** | | | |
| 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: |  |

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| **Section 6 Registration**  **Please record your current AHPRA registration number and attach a photocopy of your registration certificate to the application:** | | | | | | | | | |
| State(s): |  | Registration Number: | | |  | Expiry Date: | | / /20 | |
| 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 health practitioner 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, 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 ❒ |

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| **Section 7 Insurance and Disclosure**  Complete all sections if your engagement is as an independent contractor. Complete sections 7.5 to 7.14 if your engagement is as an employee of Healthe Care.  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.*  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. Physiotherapist, Nurse Practitioner-Cardiology)* | | |  | | | | | |
| 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? (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 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:* | | | | | | | | |
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| 7.6. Have you ever had any restrictions / conditions placed on your Health Practitioner Registration? | | | | | | 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):* | | | | | | | | |
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| 7.7 Have you previously been refused credentialing 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)* | | | | | | | | |
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| 7.8 Has your Scope of Practice been restricted, suspended, not renewed or had any written recommendations made against your accreditation 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). | | | | | | | | |
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| 7.9 Are you currently under investigation or have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance / health practitioner laws, professional misconduct, sexual assaults or assault) by: The Health Insurance Commission, an Allied Health or Nursing Board, a Health Care Complaints Commission/body, a Coroner, a Court or any other professional disciplinary or similar body? | | | | | | Yes ❒ | | No ❒ |
| *(If you answered yes to the above, please provide details)* | | | | | | | | |
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| 7.10 Do have any illness or disability which may adversely affect your fitness to practice? | | | | | | Yes ❒ | | No ❒ |
| *(If you answered yes to the above, please provide details)* | | | | | | | | |
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| 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)* | | | | | | | | |
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| **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** | | | | | | | | |

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| **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: |  |

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| **Authority:** | | | |
| * I hereby apply for accreditation at Gosford Private Hospital 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 will abide by 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) immediately proceed to suspension or termination of my Accreditation. * I will immediately notify the CEO of Gosford Private Hospital 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 or the Director of Clinical Services 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.   ***NOTE****: Receipt of certificate of coverage from your medical defence organisation/fund or professional indemnity insurer and certificate of registration* ***MUST*** *accompany this application.* | | | |
| **Applicant’s Name:** |  | | |
| **Signature** |  | **Date:** |  |
| **Witness Name:** |  | | |
| **Signature:** |  | **Date:** |  |

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| **Sponsoring practitioner must complete this part of the form**  I, endorse this application from  ***Sponsoring practitioner’s name***  ***Applicant’s name***    *Signature of sponsoring practitioner Date* |