Sunshine Private Day Surgery

Instructions:

1. Click 'Tools' on the left hand upper screen
2. Click on 'fill & sign'
3. Click on relevant areas and complete form
4. Fill in ALL relevant Information, please save and email return.

Senior medical staff with independent responsibility for patient care

This form sets a minimum information standard. Information may be added, but not deleted.

Name of medical practitioner

Surname

First name Middle name

This is a:

New application Re-credentialling Application for change of scope of practice

Please note: If you need to correct any error in your application, please initial the correction.

1. Application for scope of clinical practice

I wish to apply to undertake a scope of practice for

_____

(for example, general practitioner, general surgeon, thoracic surgeon).

The health service must verify medical registration, which can be accessed on the Medical Board of Australia website at <www.medicalboard.gov.au>.

Please attach the following to this form:

All applications/re-credentialling

- A copy of the current medical indemnity insurance certificate (if applicable); initial applications need to supply a certified copy
- Copies of relevant visa documents (if applicable)

New appointments only

- Current curriculum vitae
- Certified copies of all specialist or other qualifications, other than a primary medical degree,

if these are not listed on the Medical Board of Australia website at <http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>

- Proof of identification: 100-point test
- Working with children check (if applicable)

2. Applicant contact details

Surname

Given name(s)

Previous name(s)

Date of birth Place of birth

Residency status

(only applicable for re-credentialling/altered scope of practice if changed since last application at this health service)

Australian citizen Permanent resident Temporary resident

Professional address

Postcode

Postal address *(if different to professional address above)*

Postcode

Phone (BH) Phone (AH)

Fax Mobile/pager

Email address

Do you have a Medicare provider number for this location?

If NO, please note that you will be required to obtain one. The organisation can assist.

If YES, is it subject to any restrictions?

If restrictions apply, please provide full details.

Yes No

Site(s):

Provider number(s):

Yes No

Do you have a prescriber number?

Yes No

Prescriber number:

3. All qualifications including your primary medical degree

- New appointments – please list all your qualifications.
- Re-credentialling (or if applying to extend current scope of practice) – please list any new qualifications obtained since your last appointment.

Please provide certified copies of new qualifications obtained.

Qualifications	University/organisation	Year obtained
Primary medical degree		
Others		

Re-credentialling only	Are you requesting a change to your existing scope of practice?	Yes No
	General practitioners	
	• If YES, please go to section 4.	
	• If NO, please go to section 6.	
	Specialists	
	• If YES, please go to section 5.	
	• If NO, please go to section 6.	

4. General practitioners – new applicants and change of scope of practice only *(specialists please go to section 5)*.

4a. What scope of clinical practice are you applying for?

I wish to apply to define my scope of clinical practice to undertake the following (please select from the following groups):

Group 1	Management of health service public patients
	Management of health service private inpatients
	Emergency care
	Minor surgery – the Royal Australasian College of Surgeons' Minor Surgery Course for GPs can be used as a guide in determining relevant procedures
	Geriatrics, including residential care
Group 2 Procedural	Obstetrics
	Anaesthetics
	Procedural internal medicine
	Surgery, other than minor surgery procedures as outlined in Group 1
	Paediatrics

Group 3 Diagnostic imaging	Please specify modality/modalities for which scope of clinical practice is sought:
	Please provide evidence of appropriate radiation licence.
	(Please refer to online guidelines at <www.health.vic.gov.au/environment/radiation>.
Group 4 Non-procedural	Please specify:
	Psychiatry
	Alcohol and drugs of dependence
	Rehabilitation
	Palliative care
	Public health/infectious diseases
	Other (please provide details)

General practitioners only

4b. Other training and clinical experience

- New applications, or
- Application for a change in your scope of practice – please specify information relevant to change only.

With respect to your response to question 4a, please provide details of clinical experience and post-qualification training in the following areas.

Include the title of the specific course(s) undertaken or training undertaken or experience gained, the organisation offering the course, and the qualification obtained.

(If you received training in a specific area while working at a particular hospital or clinic, please list that hospital/clinic. If your training was received as part of rotations at a specific hospital, please list the relevant hospital.)

	Type	Organisation providing training	Date	Requested in scope of clinical practice?
Management of hospital inpatients				Yes No
Emergency medical care				Yes No
Minor surgery				Yes No
Geriatric care				Yes No
Paediatric care				Yes No
Obstetric care				Yes No
Anaesthetics				Yes No
Procedural internal medicine				Yes No
Surgery, other than minor surgery listed above				Yes No
Diagnostic imaging				Yes No
Psychiatric care				Yes No
Alcohol/drugs of dependence				Yes No

Rehabilitation medicine				Yes No
Palliative care				Yes No
Public health/infectious diseases				Yes No

Please provide further details/evidence to support your application for the proposed scope of clinical practice you are requesting from the health service. (If you require further space please attach a separate page.)

General practitioners please now go to section 6.

5. Specialists only – new applicants and change of scope of practice only

5a. Specialty information

Primary specialty		Qualifications to support this specialty:
Sub-specialty or area of special interest (if applicable)	(Please provide supporting information in 5b.)	
Other specialty (if applicable)		Qualifications to support this specialty:
Sub-specialty or area of special interest (if applicable)	(Please provide supporting information in 5b.)	
Other clinical practice		
Are you applying to reduce your current scope of practice?		Yes No

If yes, please outline reasons for the proposed reduction of scope of practice.	

Scope of clinical practice sought including, where relevant, the type of procedures you wish to undertake: (please use additional pages if required)

5b. Other training and clinical experience – new applicants and change of scope of practice only

Please provide details of relevant clinical experience and post-qualification training to support your application.

Include the title of course(s) undertaken, the organisation offering the course(s) and the qualification(s) obtained.

6. Clinical appointments

Please provide details on all current and previous clinical appointments held within the past five years (including names of organisations and dates of appointment) or other places of practice (for example, general practice, other hospitals or non-public-hospital-based specialty practice).

Organisation	Name and type of appointment	When did you work in that role?
		to
		to
		to
		to
		to
		to
		to
		to
		to

7. Medical registration and other matters

Please refer to <www.medicalboard.gov.au> for definitions.

What is your Medical Board of Australia registration number?	
Is this *general* registration?	Yes No
Is this *specialist* registration?	Yes No If yes, please specify
Is this *limited* registration?	Yes No If yes, please specify: Area of need Public interest Teaching or research
If you have *limited* registration, and/or you are to be supervised or under a college peer-review process, please provide details of this process.	
Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a medical practitioner?	Yes No
Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board either in Australia or elsewhere?	Yes No
Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country?	Yes No
Have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration either in Australia or elsewhere?	Yes No
Have you ever been denied a scope of clinical practice that you requested?	Yes No
Have you ever chosen to reduce your scope of practice?	Yes No

Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	Yes No
Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?	Yes No
Are you the subject of current or pending criminal charges?	Yes No
If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'Confidential for medical director only' appended to this application, and indicate here that additional information is provided separately in this manner.	
Are you registered as a medical practitioner in any other country?	Yes No If yes, please specify.
Have you ever been registered as a medical practitioner in any other country?	Yes No If yes, please specify.
Do you have a current working with children check? - see website* This is required for staff regularly providing services to children in paediatric wards. *Please attach a photocopy of your current card.*	Yes No N/A Card number: Expiry date:

*Working with children information can be found at <www.justice.vic.gov.au/wps/wcm/connect/justlib/Working+With+Children/Home>.

8. Medical indemnity insurance information

<table>
<tr><td rowspan="3">Current private medical indemnity insurance cover (if applicable).

Please attach a copy of your current policy renewal certificate. New appointments need to attach a certified copy.</td><td>Name of insurer:</td></tr>
<tr><td>Policy number:</td></tr>
<tr><td>Expiry date:</td></tr>
<tr><td>Is your proposed scope of private clinical practice reflected in or covered by your current medical indemnity insurance?</td><td>Yes No N/A</td></tr>
<tr><td>Have there ever been, or are there currently pending, medical indemnity claims, settlements or judgements against you?</td><td>Yes No</td></tr>
<tr><td>Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?</td><td>Yes No</td></tr>
<tr><td colspan="2">If the answer to either of the above two questions is YES, please provide a detailed explanation and specify the name of the relevant medical defence organisation/insurer.</td></tr>
</table>

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

9. Academic appointments/teaching experience

Please provide details of current and previous university or hospital teaching appointments held within the past five years (including organisations and dates of appointment).

Organisation	Status/level	Term of appointment
		to
		to
		to
		to
		to
		to
		to

10a. Continuing professional development

Have you met the continuing professional development requirements of the Medical Board of Australia? Refer to AHPRA's registration standard for details at <www.medicalboard.gov.au/Registration-Standards.aspx>.	Yes No

Provide a copy of your current college certificate, annual statement of participation or evidence of relevant continuing professional development (such as a CPD logbook).

10b. Quality activities (new appointments only)

For doctors undergoing re-credentialling these activities should be recorded through the *Partnering for performance* process, for example, participation in clinical review/audit/peer-review activities.

Have you participated in regular clinical reviews, audits and/or peer-review activities in any clinical setting?	Yes No
If YES, please provide details of these activities (provide attachments if necessary).	

11. Grand rounds/health service educational activities

Are you prepared to conduct a grand round or other educational activities at this health service?	Yes No

12. Health status

Do you have a disability or health issue that: • may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application? • may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application? • may be relevant to determining your scope of practice?	Yes No

If you answered YES, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included.

This information can be provided on this form or, alternately, you can provide the information in a sealed envelope marked 'Confidential for medical director only' appended to this application. Indicate here if additional information is being appended.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure you can work at the health service in a way that ensures patient safety.

13. Referees (new appointments or expanding scope of practice only)

Please provide details of at least two referees who preferably work largely within the specialty being applied for, who have been in a position to judge your experience and performance during the previous three years and who have no conflict of interest in providing a reference.

Referee 1

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

Referee 2

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

Referee 3

Name	
Current position	
Professional address	
	Postcode
Phone (BH)	Phone (mobile)
Email address	

14. Agreement/undertakings

I understand that in assessing my application for appointment as a medical practitioner the health service will make additional enquiries as to my suitability for the position.

New applications only

I understand the health service will conduct a routine police check.	Yes No

New appointments and expanding scope of practice only

I authorise the health service to seek information from my referees as to my past experience, performance and current fitness to practise.	Yes No
I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them.	Yes No

All applications

I accept that the health service will obtain information relevant to my application from the Medical Board of Australia and any other authority that regulates health practitioners.	Yes No
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	Yes No
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes No
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes No
I agree to abide by the organisation's and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes No
I agree to notify the director of medical services/medical leader of any event/situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the director/medical leader would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).	Yes No

I agree to participate in this health service's performance development and support process (*Partnering for performance* or equivalent).	Yes No
I agree to promptly notify the director of medical services/medical leader of any adverse clinical incident I am involved in, or become aware of.	Yes No
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes No
Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	Yes No

15. Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant	Date

If, for any reason, you are unable to sign the declaration above, please explain the circumstances.

Please note: the information collected on this form will be used by the <insert health service name> Credentialling and Scope of Clinical Practice Committee(s) to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

<Insert health service name> operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of <insert health service name> privacy and confidentiality policies are available upon request.

Health service use only

Applicant name	
Item	Checked/comments
1. Proof of identification	
2. Working with children certificate (if applicable)	
3. Contact details provided	
4. Provider number	
5. Prescriber number	
6. Qualifications	
7. Training and experience (if required)**	
8. Clinical appointments (if required)**	
9. Medical registration	
10. Medical indemnity cover currency	
11. Academic appointments / teaching experience	
12. Continuing professional development	
13. Grand rounds (if applicable)	
14. Health status	
15. Referees (if required)**	
16. Existing contract/employment arrangements checked and relevant documentation available (if required)**	
17. Declaration signed	
** Not required for reappointment at same health service with no change in scope of practice.	

Other comments:	
Application details checked by <insert name>	
Signature	Date
Letter to applicant advising outcome of application	Yes Copy attached

100 points – verification details

Type of check	Available points	Notes
Passport (current or expired by less than two years, not cancelled) Citizenship certificate (Australian only) Birth certificate (original or extract) Birth card issued by the Victorian Registry of Births, Deaths and Marriages	70	Must contain name and a photo. Select one only.
Written reference Written reference from an acceptable referee from a financial institution	40	Select one only. Referee to have known the signatory for at least 12 months. Both signatory and referee must sign the reference.
Driver's licence. Renewed, interim, provisional, truck or learner's Other acceptable government-issued licences include boat, gun or pilot Public Service Employee Identification Card Pension or government Health Care Card (reference number required) Identification card issued by a tertiary education institute	40 40 40 40 40	Must contain name, expiry date, a photo or signature.
Letter from a current employer (current or must have been employed by the employer within the past two years)	35	Must be on letterhead or company seal. Both employer and employee's signature must be on the letter, along with the name and address of the employee.
Medicare card Overseas or international driver's licence or Proof of Age card	25 25	

Financial institution's credit card, cash card or passbook	25	Only one current card/passbook can be accepted from each financial institution. You may supply details from several different institutions but cannot solely rely on this form of identification.
Type of check	Available points	Notes
Rating authorities Rate notice (current). Provide the deposited plan (DP) number	35	
Public utility (water rate notice, electricity, gas or telephone account – no mobile accounts). Take a *current* notice with you.	25	
Statement from landlord, managing agent or owner of customer premises	25	Take letter, rental contract or rent receipt with you.