NEW and RENEWAL APPLICATION FOR ACCREDITATION

as a …… Practitioner

Specify type of Practitioner

Surgeon / Anaesthetist / Physician / Surgical Assistant / Allied Health Practitioner

at_____ Hospital

Enter name of Hospital here

Please attach a copy of your ***Curriculum Vitae***

For Re-application complete shaded section only

TITLE	FIRST NAMES	SURNAME	
SECOND INITIAL	PREFERRED FIRST NAME		DATE OF BIRTH
PROVIDER NUMBERS:			
PRESCRIBER NUMBER:			
PROFESSIONAL ADDRESS:			
PRIMARY:		SECONDARY:	
NAME OF PRACTICE MANAGER/ PERSONAL ASSISTANT:			
TELEPHONE:		FAX:	
MOBILE PHONE:		PAGER:	
AFTER HOURS:		EMAIL ADDRESS:	
PRIVATE ADDRESS:			
PLEASE SEND ALL CORRESPONDENCE TO MY	☐ PRIVATE ADDRESS	☐ PROFESSIONAL ADDRESS	

REGISTRATION / PRACTICING CERTIFICATE

ARE YOU LICENSED TO PRACTICE MEDICINE/ DENTISTRY IN THE STATE OF SOUTH AUSTRALIA? ☐ YES / ☐ NO

REGISTRATION NUMBER:……..EXPIRY DATE……

Are there or have there been any adverse findings, conditions, restrictions or undertakings imposed on your registration? ☐ YES / ☐ NO

Please enclose a copy of your current Practising Certificate and particulars of any adverse finding, condition, restriction and/ or undertaking.

PROFESSIONAL INDEMNITY COVER / MEDICAL DEFENCE MEMBERSHIP

INSURANCE COMPANY / MEDICAL INDEMNITY INSURER

POLICY NUMBER:	EXPIRY DATE:

POLICY COVER/ INSURING CLAUSES:

DOES YOUR MEMBERSHIP COVER THE TYPES OF PRIVILEGES APPLIED FOR? ☐ YES / ☐ NO

Does your insurance impose any exclusions, restrictions or conditions on your cover? ☐ YES / ☐ NO

Please enclose a copy of your current membership insurance policy renewal and provide details of any exclusion, restriction or condition.

CLAIMS

Have you ever had a judgment made against you or have you ever made or had made on your behalf an out of court settlement regarding your medical practice in any state or territory of Australia or any other country? ☐ YES / ☐ NO

If YES, please provide dates and particulars

……

Have there ever been any serious adverse findings made against you which would be relevant to your appointment (eg: breach of insurance/ medical laws, professional misconduct, sexual assaults or assault) by the Health Insurance Commission, a Medical Board, a Health Care Complaints Commission/ Body, a Court or other professional, disciplinary or similar body? ☐ YES / ☐ NO

If YES, please provide dates and particulars

……

CLINICAL PRIVILEGES

Have you ever had your clinical privileges and/ or appointment at any hospital or day procedure centre denied, reduced, suspended or revoked or have you had conditions attached to that appointment for any reason? ☐ YES / ☐ NO

If YES, please provide dates and particulars

……

ARE YOU ACTIVELY INVOLVED IN CME ACTIVITIES? ☐ YES ☐ NO

DO YOU MEET THE REQUIREMENTS OF YOUR COLLEGE CME ACTIVITIES? ☐ YES ☐ NO

UNDERGRADUATE QUALIFICATIONS:

DEGREE	INSTITUTION	YEAR

POST GRADUATE QUALIFICATIONS:

Diplomas, Certificates, Degrees, Memberships & Fellowships

QUALIFICATIONS	AUTHORISING BODY	SPECIAL COMMENTS	YEAR

HOSPITAL APPOINTMENT(S) HELD IN THE LAST 10 YEARS:

ACTIVE POSITION HELD	HOSPITAL	CLINICAL PRIVILEGES	DATE FROM	DATE TO

IF PUBLIC APPOINTMENTS ☐ FULL TIME ☐ PART TIME NUMBER OF SESSIONS

If full time do you have written consent of the public hospital to engage in private practice outside of the hospital?

YES / NO

If YES provide a copy of the approval.

SPECIAL PROFESSIONAL INTERESTS / COLLEGE MEMBERSHIPS

APPOINTMENT SOUGHT (Please tick one) ☐ PERMANENT ☐ TEMPORARY from to

- ☐ **Anaesthesia**
  - ☐ Adult
  - ☐ Cardiac
  - ☐ Paediatrics
  - ☐ Pain Management
- ☐ **Dental**
  - ☐ Oral and Maxillofacial
- ☐ **Dermatology**
- ☐ **Emergency Medicine**
- ☐ **ENT Surgery**
  - ☐ Adult
  - ☐ Paediatric
  - ☐ Paediatric endoscopic
  - ☐ Head and Neck
- ☐ **Gastroentorology**
  - ☐ Endoscopy
  - ☐ ERCP
- ☐ **General Practice**
- ☐ **General Surgery**
  - ☐ Breast endocrine
  - ☐ Colo rectal
  - ☐ Endoscopy
  - ☐ Laparoscopy
  - ☐ **Intensive Care**
  - ☐ **Neonatology**
  - ☐ **Obstetrics & Gynaecology**
    - ☐ Gynaecology general
    - ☐ Obstetrics
    - ☐ Gynaecology oncology
- ☐ **Occupational Medicine**
- ☐ **Oncology**
  - ☐ Medical oncology
  - ☐ Radiation oncology
- ☐ **Ophthalmology**
  - ☐ Adult
  - ☐ Paediatric
- ☐ **Oral & Maxillofacial surgery**
- ☐ **Orthopaedics**
  - ☐ Adult
  - ☐ Paediatric
- ☐ **Paediatric medicine**
- ☐ **Paediatric surgery**
- ☐ **Palliative care**
- ☐ **Pathology**
  - ☐ Clinical haematology
- ☐ **Physicians/ internal medicine**
  - ☐ General medicine
  - ☐ Endocrinology
  - ☐ Geriatrics
  - ☐ Renal medicine
  - ☐ Respiratory physicians
  - ☐ Rheumatology
  - ☐ Cardiology
  - ☐ Neurology
  - ☐ Other……
- ☐ **Plastic & Reconstructive Surgery**
  - ☐ Hand surgery
  - ☐ Facio Maxillary
  - ☐ Plastic reconstructive
  - ☐ Head and neck
  - ☐ Minor skin lesions
- ☐ **Psychiatry**
- ☐ **Radiology**
- ☐ **Rehabilitation medicine**
- ☐ **Surgical Assisting**
- ☐ **Urology**
  - ☐ Adult
  - ☐ Paediatric
- ☐ **Vascular Surgery**

- ☐ **Special Equipment Use**
  - ☐ Endoscope & Colonoscope
  - ☐ CO2 Laser
  - ☐ Lithotripter
  - ☐ Laparocope
  - ☐ Phaco emulsifcator
  - ☐ Fluoroscan

ARE YOU INTENDING TO PERFORM ADVANCED ENDOSCOPY AND / OR LASER SURGERY? ☐ YES ☐ NO

Medical Practitioners performing advance Endoscopy and / or Laser surgery are required to provide details of experience, qualifications and / or education verifying their competence with the equipment and / or procedure. Please attach a copy of relevant details to this Accreditation application.

SCOPE OF PRACTICE

List here, principle procedures you expect to perform. Note, further details regarding this may be requested.

AFTER HOURS / EMERGENCY CARE PROVISIONS

Please provide details of a registered/ nominated practitioner from the same discipline who is accredited at this hospital who can be contacted for "back up" or "emergency" cover, should the Hospital be unable to contact you.

FIRST NAME:	LAST NAME:
ADDRESS:	
TELEPHONE:	AFTER HOURS:
MOBILE PHONE:	

If the Hospital has an Emergency Department would you be prepared to participate in an on-call roster arrangement for the Emergency Department?

☐ YES ☐ NO

REFERENCES (for new application only)

Please provide details or three (3) Referees appropriate to your specialty and area of practice and who can attest to your recent practice and who are not related to you.

SPECIALTY: ……

NAME:
……..

ADDRESS: ……Postcode……

SPECIALTY: ……..

NAME:
……

ADDRESS: ……Postcode……

SPECIALTY: ……..

NAME: ……

ADDRESS: ……

ADDITIONAL INSURANCES

In accordance with the Hospital conditions I am aware of the Board's strong recommendation to hold additional Insurances to cover the following:

PERSONAL INJURY AND PERSONAL PROTECTION INSURANCE

1. Injury caused during the performance of duties in the Hospital
2. Costs associated with an injury
3. Loss of income associated with an injury

PUBLIC LIABILITY

1. Damage to Hospital property
2. Damage to property in the physical and legal control of the applicant; and / or
3. Injury to Hospital employees.

DECLARATION

Registration and Indemnity

I declare that I am currently registered to practice in South Australia and that I hold professional indemnity insurance with an approved insurer.

I authorise …….. to obtain information on an annual basis from the registration board / indemnity insurer nominated, regarding the currency of my registration and indemnity insurance cover..

Specialist Directory

I authorise North Eastern Community Hospital to include my details in their Specialist Directory which may be distributed to General Practitioners.

☐ I declare that I am the person named in this application, and that, to the best of my knowledge, statements contained herein are true in substance and in fact.

☐ I agree to be bound by the conditions set out in this application form and the By-Laws and rules of the hospital.

☐ I undertake to notify the Hospital if my clinical privileges are changed at any other hospital or day procedure centre and notify any change in my indemnity insurance cover.

☐ I acknowledge by signing the application for accreditation or re-accreditation that I hereby authorise the Hospital its Officers and the Clinical Privileges Committee to seek information as to my past experience, performance and current fitness to practice.

☐ *I acknowledge that the granting, continuation or renewal of privileges at this hospital do not constitute or imply any contractual relationship with the hospital and that these privileges may be discontinued in accordance with the hospital By Laws/ Rules for Practitioners.*

☐ I hereby apply for appointment to the Hospital, with privileges in the fields specified.

Signature……Date……..