SOUTHPORT DAY HOSPITAL

CREDENTIALING & SCOPE OF CLINICAL PRACTICE APPLICATION FORM

PRIVATE & CONFIDENTIAL

TYPE OF APPLICATION: (PLEASE TICK)

☐ **NEW APPLICATION** ☐ **RENEWAL APPLICATION** ☐ **CHANGE TO SCOPE OF CLINICAL PRACTICE**

PLEASE COMPLETE THE FOLLOWING DETAILS AND EMAIL TO: k.calamatta@southportdayhospital.com.au **(Tel: 07 5620 1000 / Fax: 07 5613 2010)**

PERSONAL / CONTACT INFORMATION			
SURNAME		**GIVEN NAMES**	
PREFERRED TITLE		**PREFERRED NAME**	
FORMER NAMES		**DATE OF BIRTH**	
HOME ADDRESS		**PHONE (HOME)**	
BUSINESS ADDRESS & NAME		**PHONE (BUSINESS)**	
EMAIL		**MOBILE NUMBER**	
AHPRA REGISTRATION			
AHPRA REGISTRATION #		**EXPIRY DATE**	
PROVIDER NUMBER		**PRESCRIBER NUMBER**	

Q1. Are there any conditions or undertakings currently attached to this registration?

YES ☐ NO ☐ If yes, please attach details to this application.

Q2. Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by AHPRA?

YES ☐ NO ☐ If yes, please attach details to this application

HEALTH OMBUDSMAN

Q1. Are you aware of any complaints lodged with the Health Ombudsman?

YES ☐ NO☐ If yes, please attach details to this application

PROFESSIONAL INDEMNITY INSURANCE			
PROFESSIONAL INDEMNITY INSURER		**CATEGORY OF COVERAGE**	
MEMBER NUMBER		**EXPIRY DATE**	

Q1. Does your membership fully cover the scope of clinical practice you have applied for?

YES ☐ NO ☐

Q2. Has your medical defence insurer or any medical defence insurer of which you have been a member ever applied conditions or refused to renew your cover or membership (in part or full)?

YES ☐ NO ☐ If yes, please attach details to this application

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EMERGENCY CONTACT PERSON			
NAME		RELATIONSHIP	
PHONE (WORK)		PHONE (HOME)	
MOBILE		EMAIL	

CLINICAL PRACTICE SOUGHT (PLEASE TICK)
☐ SPECIALIST MEDICAL PRACTITIONER ☐ SURGICAL ASSISTANT (NO ADMIT RIGHTS) ☐ ALLIED HEALTH PRACTIONER ☐ DENTAL PRACTITIONER ☐ GENERAL PRACTITIONER ☐ REGISTERED NURSE (EMPLOYED BY VMO)
CLINICAL PRIVILEGES SOUGHT (PLEASE TICK)
☐ ADMITTING RIGHTS ☐ SURGICAL ☐ SURGICAL ASSIST ☐ ALLIED HEALTH ☐ ANAESTHESTIC ☐ CONSULTING ☐ PROCEDURAL

SCOPE OF CLINICAL PRACTICE REQUESTED PLEASE DETAIL BELOW ALL PROCEDURES TO BE PERFORMED	
ANTICIPATED VOLUME & FREQUENCY (PER WEEK/FORTNIGHT/MONTH)	

CLINICAL SCOPE OF PRACTICE – MEDICINES PLEASE DETAIL BELOW ANY ENDORSEMENTS AND/ OR RESTRICTIONS ON YOUR AHPRA REGISTRATION RELATING TO YOUR CLINICAL PRACTICE WHICH LIMITS OR PROHIBITS YOUR ABILITY TO - ADMINISTER, PRESCRIBE AND SUPPLY MEDICINES
Q 3. Has there been any prior or are there any current disciplinary action or professional sanctions imposed by any registration board, Medicare, Complaints body; criminal investigation or conviction; physical or mental condition or substance abuse problem that could affect your ability to exercise the requested scope of clinical practice? ☐ NO ☐ YES If yes, please attach details to this application.

ACADEMIC QUALIFICATIONS (PLEASE COMPLETE BELOW OR ATTACH CURRICULUM VITAE		
QUALIFICATION	DATE OBTAINED	ACCREDITED TRAINING ORGANISATION

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ACADEMIC APPOINTMENTS (PLEASE COMPLETE BELOW OR ATTACH CURRICULUM VITAE)		
ORGANISATION	**STATUS/LEVEL**	**TERMS OF APPOINTMENT**

CONTINUING PROFESSIONAL DEVELOPMENT (PLEASE LIST FOR PAST 12 MONTHS – OR ATTACH CURRICULUM VITAE)		
DATE	**EDUCATION SESSION TITLE**	**PROVIDER**

PROFESSIONAL ASSOCATIONS/MEMBERSHIPS (PLEASE LIST BELOW OR ATTACH CURRICULUM VITAE)	
ASSOCIATION	**TYPE OF MEMBERSHIP**

CURRENT/PREVIOUS CLINICAL APPOINTMENTS PLEASE LIST BELOW WHERE YOU ARE CURRENTLY OR HAVE PREVIOUSLY BEEN CREDENTIALED TO A PRIVATE OR PUBLIC HEALTH CARE FACILITY - (OR ATTACH CREDENTIALING APPOINTMENT LETTER)		
ORGANISATION	**SCOPE OF PRACTICE**	**DATES**

Q1. Have you previously been refused clinical privileges at another health care facility?

YES ☐ NO ☐ If yes, please attach details to this application.

Q2. Has your scope of clinical practice and/or appointment at any Hospital or Day Procedure Centre ever been reduced, suspended or revoked (including if done by mutual agreement) or have you had conditions attached to that appointment for any reason?

YES ☐ NO ☐ If yes, please attach details to this application.

Please note a senior executive of the Hospital may contact the facility.

NOMINATION OF EMERGENCY DEPUTY MEDICAL OFFICER WHO CAN ATTEND YOUR PATIENTS IN YOUR ABSENCE OR IN AN EMERGENCY	
NAME	
SPECIALITY	
CONTACT NUMBER (MOBILE)	

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REFEREES PLEASE PROVIDE TWO (2) PROFESSIONAL REFEREES (AT LEAST ONE FROM YOUR OWN PROFESSION) WHO CAN ATTEST TO YOUR RECENT PRACTICE AND HAS KNOWN YOU FOR THE PAST THREE (3) YEARS			
NAME	**ADDRESS**	**PHONE (MB)**	**EMAIL**

NOTE: THE HOSPITAL WILL EMAIL A REFEREE REPORT TO YOUR NOMINATED REFEREES

DECLARATION

1. I authorise Southport Day Hospital, its employees, officers and the Medical Advisory Committee (MAC) to obtain information on an annual or as necessary basis from the registration body/indemnity insurance organisation as nominated in this application, regarding the currency of my registration/membership of that body/organisation.
2. I authorise Southport Day Hospital, its employees, officers and the Medical Advisory Committee (MAC) to verify with relevant individuals, external organisations and nominated referees the validity of all claims, including complaints made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history, claims and legal proceedings.
3. I declare that I have no physical or mental condition or substance abuse problem that could affect my ability to exercise the scope of clinical practice requested or that would require any special assistance in or to enable me to exercise that scope of clinical practice safely and competently. I undertake to notify SDH if this statement becomes incorrect in the future.
4. I declare that my medical indemnity/professional indemnity cover is adequate and appropriate for the clinical privileges and activity, which is the subject of this application.
5. I declare that I am the person named in this application and have provided relevant evidence by way of current drivers licence or passport and that the information provided by me in this application and in connection with this application is accurate and complete and is not misleading or deceiving or likely to mislead or deceive.
6. I understand that if I have provided misleading or deceptive information, or information which is likely to mislead or deceive, the SDH's MAC may (in its absolute discretion) consider that I do not have "current fitness' under the Hospital By-Laws.
7. In applying for appointment I acknowledge that I have been provided with, and read, a copy of the Hospital By-Laws and if appointed, agree to abide by the By-Laws and policies and procedures of SDH, including any annexure or variation to the By-Laws during the tenure of my appointment, all relevant legislative requirements (including compliance with Health Ombudsman Standards) and any terms and conditions which are attached to my appointment by the board/Licensee.
8. I understand that non-compliance with the Hospital By-Laws may be grounds for suspension, termination or imposition of conditions on my clinical privileges.
9. I undertake to notify SDH promptly and in writing, if my scope of clinical practice is altered in any way at any other hospital or day procedure centre.
10. I undertake to immediately notify SDH If I become aware that I have developed a condition which would affect my ability to safely provide care to my patients.
11. I undertake to immediately notify SDH if I am charged with or convicted of an indictable offence.
12. I agree to attend Committee and clinical meetings at the facility to support my discipline within the facility and to participate in any clinical quality assurance activities including submitting my practice to clinical audit or peer review, in conjunction with the Hospital, the MAC or clinical specialty committees if required by SDH.
13. I undertake to notify SDH should any information provided in this application appointment vary in any way.
14. I acknowledge and agree to release and indemnify SDH from and against all claims, including legal costs, out of a decision to suspend or terminate my accreditation or to not re-appoint me in circumstances set out in the Hospital By-Laws.
15. In the event of myself or the aforementioned practitioner(s) being unavailable in the case of an emergency, I am agreeable to the facility seeking urgent alternative assistance with authority to be exercised only after consultation with the facility Medical Director, Director of Nursing,, or other duly authorised person.

VISITING PRACTITIONER SIGNING			
APPLICANT NAME			
APPLICANT SIGNATURE		**DATE**	
WITNESS SIGNING			
WITNESS NAME			
WITNESS SIGNATURE		**DATE**	

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PROVISIONAL CREDENTIALING

The Medical Advisory Committee (MAC) Chairman, or in his absence the Director of SDH, or at least two MAC members may grant provisional privileges to a visiting practitioner upon receipt of a full application, for a period not exceeding 120 days, or the next meeting of the MAC, whichever is the sooner.

EMERGENCY CREDENTIALING

The MAC Chairman, or in his absence, the Director of SDH, a MAC member, or the Director of Nursing, may grant emergency credentialing.

Emergency credentialing is only granted where a patient may be at risk of serious harm if treatment is not provided and no medical practitioner with an appropriate authorised scope of clinical practice is available.

The Scope of Clinical Practice (SoCP) may be defined for emergency situations with appropriate limitations and will be fully documented on a VP application at a time immediately before or after it is granted.

CREDENTIALING PERIOD

I understand that Clinical Privileges are granted for a period not exceeding **three (3) years.**

RENEWAL OF CREDENTIALING

I understand that my appointment will be reviewed in **three (3) years** or earlier if considered necessary.
Re-credentialing will automatically be granted to existing Visiting Practitioners (VPs) at the end of their original term, providing there are no changes to the original application.

Prior to re-credentialing, the MAC will review the VPs existing application, AHPRA registration & medical indemnity status. You will be notified of your re-credentialing status in writing.

THIS APPLICATION WILL BE SUBMITTED TO THE MEDICAL ADVISORY COMMITTEE FOR DUE CONSIDERATION AND YOU WILL BE NOTIFIED ACCORDINGLY.

APPLICATION CHECKLIST:

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS TO THIS APPLICATION – INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED:

- Copy of current AHPRA Registration
- Copy of current Medical/Professional Indemnity insurance
- Copy of Curriculum Vitae
- Copy of Passport or/ Drivers license with photo identification
- Certified copy of valid visa which provides eligibility and the right to work in Australia (if applicable)
- Criminal history check
- Copy of recent Continuing Professional Development undertaken in last 12 months
- Copy of credentialing at other health care facilities (if applicable)
- Two written referee reports – will be emailed to your nominated referee by the hospital – please provide email addresses.