6 Lubich Way
Mira Mar Albany 6330
PH: 08 614 614 66
ABN: 1918239231

REQUEST FOR CREDENTIALLING AT ALBANY DAY HOSPITAL.

Thank you for your expression of interest in Clinical Accreditation at Albany Day Hospital, a Montserrat Day Hospital facility.

Please complete and return the accompanying *Application for Clinical Accreditation and Defining Scope of Clinical Practice*. Please include with the Application;

a) CV
b) Photographic ID (Drivers Licence or Passport)
c) Evidence of Medical Registration and Indemnity Insurance,
d) Contact details of at least 3 referees,
e) Documentation in relation to 'false' answers in Declaration
f) Any required evidence of competency.

Please return the Application and required documents to:

Chief Executive Officer
Albany Day Hospital
6 Lubich Way
Mira Mar WA 6330
E: fcooper@montserrat.com.au
Ph: 0428662886

Thank you for your enquiry and I look forward to reviewing your application.

Yours sincerely

Fiona Cooper
CEO
Albany Day Hospital
Bunbury Day Hospital
Montserrat Regional WA Manager

Application for Clinical Accreditation and Defining Scope of Clinical Practice

Applicant Details			
Title	Doctor ☐ Professor ☐ Mr ☐ Ms ☐ Mrs ☐ Other ☐		
Surname:		Given Name/s:	
Previous Name:	Please include your previous (or maiden) name that appears on birth certificate or APHRA registration		
Date of Birth:		Place of Birth:	
Professional Address:			
Intended First List Date:			

AHPRA Registration number:

Associated Organisation or practice:	
ADH **Provider Number** *to be advised once received from Medicare*	
Are you a 'Known Gap' or 'No Gap' Provider?	Yes ☐ No ☐

Telephone Numbers: (Please provide at least two telephone numbers)

Business:		Private:	
Mobile:		Fax:	
Email Address:			
Website:			

Postal Address (If different to Professional Address)	
Private Address:	
Preferred method of correspondence:	Email ☐ Postal Address ☐ Private Address ☐

Emergency Contact - in the event I am unable to be contacted for a clinical emergency. *Person nominated must be appropriately **qualified**, **registered** (APHRA) and **insured**.*

Name:		Phone:	

Nominated Sites: *Please indicate the site/s you are seeking clinical privileges for*

Bunbury ☐ Albany ☐

Australian Residency status:

Australian citizen ☐ Permanent resident ☐ Temporary resident ☐

Identification

Please provide an identity document that includes a **photograph** such as passport or Drivers licence. ☐

Qualifications/Training:

Qualifications	*University/Organisation*	*Country*	*Year Attained*

Please refer to CV for supporting information or documentation ☐

Appointments/Education

Previous Clinical Appointments (list chronologically – attach separate list if insufficient space)

Appointment	*Organisation*	*Country*	*Dates (approx.)*

Please refer to CV for supporting information or documentation ☐

Lifetime Registration History (list chronologically – attach separate list if insufficient space)

Registration Authority	*Dates Registered*	*Country*	*Conditions or sanctions*

Are there any current sanctions/restrictions imposed on your Medical Registration? **YES** ☐ **NO** ☐

Current Clinical Appointment/s (List appointments that would continue concurrently at other private or public health care facilities, including time commitments)

Appointment	*Scope of Practice*	*Organisation*	*Time Commitment*

Academic Appointments (attach separate list if insufficient space)

Organisation	*Status/Level*	*Term of Appointment*

Are you undertaking the requirements for Continuing Medical Education, re-certification etc. required by AHPRA?
*** GP Anaesthetists: Please provide evidence of continual education in Anaesthesia, Emergency Management and/or the Diploma of Rural General Practice Anaesthesia (DRGPA)**

YES ☐ Please attach supporting documentation

College/Organisation	*Program*	*Date Completed/Currently Enrolled*

☐ **NO** Please explain

Do you subject your clinical work to quality activity mechanisms including audit, peer review etc?

YES ☐ Please attach supporting documentation

College/Organisation	Program	Date Completed/Currently Enrolled

☐ **NO** Please explain

Have you had previous experience in Day Hospital Facility? **YES** ☐

Organisation	Position	Dates (approx.)

Indemnity Insurance

Medical Indemnity Insurance

Do you have current Medical Indemnity Insurance at the appropriate level? **YES** ☐ **NO** ☐

Insurance Company _ Expiry Date _ _ _ _ _ _ _ _ _ _ _ _

Scope of Practice _

Please Note: Please find attached at the back of this application, Authority for Montserrat Day Hospitals to obtain your insurance information for the next 3 years.

References

Please list the names and contact details of at least 3 professional referees who can comment on your skills and work ethic in the areas for which you are seeking clinical privileges.

1.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

2.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

3.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

Specialist Scope of Practice

Specialist Scope of Practice sought in the field/s of:
NB: Must be registered in the indicated speciality with the Australian Health Practitioner Registration Agency (AHPRA) to complete this section.

Anaesthetists, *please provide information of specialties with which you have evidence of experience. •Favourable weighting will be given to GP Anaesthetists who have a Diploma of Rural General Practice Anaesthesia (DRGPA) with oversight from the Joint Consultative Committee on Anaesthesia (JCCA).*

Anaesthesia ☐ Adults ☐ Paediatric* (Over 10yrs meeting specific criteria as per Medical By-Laws) ☐ Emergency Management **Please attach evidence of training and currency of practice.* *How many lists performed in the past 12 months: _____*	**IVF, Obstetrics & Gynaecology** ☐ Gynaecology ☐ Uro-gynaecology *Please specify procedures and attach evidence of competency.*	**Gastroenterology**** ☐ Gastroenterology ☐ Colonoscopy ☐ Other (please detail) *** Must have Conjoint Committee Certification – Please attach*
Dental* ☐ General Dental ☐ Paediatric **Please specify procedures and attach evidence of competency*	**Dermatology*** ☐ Adult ☐ Paediatric **Please specify procedures and attach evidence of competency*	**ENT*** ☐ Adult ☐ Paediatric (10yrs +) **Please specify procedures and attach evidence of competency*
Orthopaedics ☐ Adult ☐ Paediatric **Please specify procedures and attach evidence of competency*	☐ **Ophthalmology** ☐ Adult ☐ Paediatric **Type of Anaesthesia;** ☐ Subtenons ☐ Peribulbar Other:_____ **Please specify procedures and attach evidence of*	**General Surgery*** ☐ Adult ☐ Paediatric **Please specify procedures and attach evidence of competency*
Plastic and Reconstructive Surgery* ☐ Adult ☐ Paediatric **Please specify procedures and attach evidence of competency*	**Cosmetic Surgery*** ☐ Adults **Please specify procedures and attach evidence of competency*	**Urology*** ☐ Adult ☐ Paediatric **Please specify procedures and attach evidence of competency*

Categories: Specialist Practitioner ☐ Dentist ☐ Other ☐_ _ _ _ _ _ _ _ _ _ _ _ _

Privileges: Assist ☐ Anaesthetic ☐ Surgical ☐ Other ☐_ _ _ _ _ _ _ _ _ _ _ _ _

Applicant Declaration		
*I declare that all the following statements are **TRUE** or **FALSE** as indicated in the tick boxes. Please tick (✓)*	**TRUE**	**FALSE**
I have never been subject to an adverse finding or had conditions or undertakings attached to my registration and I am not currently under investigation. This may include 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 Coroner, a Court or any other professional disciplinary or similar body.	☐	☐
My right to practise and/or scope of clinical practice is not under investigation and/or has never been denied, restricted, suspended, terminated or otherwise modified in or by any other health care organisation (including overseas organisations, health facilities, learned colleges or other official bodies	☐	☐
I am not and have never been the subject of investigation by a State Statutory Complaint Body or other similar body interstate or overseas.	☐	☐
A Medical Defence Union or Fund has never refused to renew my membership.	☐	☐
I have not been subject to criminal investigation or conviction	☐	☐
My clinical work is assessed by quality assurance mechanisms including clinical audit and peer review processes. I am not aware of any data from patient records, clinical audit, peer review processes or quality activities which reflects adversely on the outcomes of my clinical practice.	☐	☐
I participate in the continuing medical education program, maintenance of professional standards program, or similar, of my College or Society and I am current with the requirements of that program.	☐	☐
I agree to abide by the Policies and Standards of Albany Day Hospital and Montserrat Day Hospitals in regards to Privacy, Informed Consent (Financial and Clinical) and Open Disclosure.	☐	☐
I agree to provide Albany Day Hospital with data regarding antibiotic prescribing when requested.	☐	☐
I have not had any patient complaints against me in the past 12 months.	☐	☐
I have no physical or other conditions or substance abuse that may limit my ability to exercise the scope of practice which has been granted/requested	☐	☐
I do not have any criminal charges pending against me.	☐	☐
I have not been convicted of a criminal offence.	☐	☐
I have never been convicted of a drug or alcohol related offence.	☐	☐

Please comment below if you are unable to answer "True" to any of the above questions, and attach any relevant documentation.

_____

_____

Statement of Acceptance

I, ... authorise Albany Day Hospital to obtain information on an annual basis form the registration body as nominated in this application, regarding currency of my registration with that body or organisation. I will ensure Albany Day Hospital is provided with current and valid evidence of membership with an Indemnity insurance organisation.

- ☐ I authorise Albany Day Hospital to contact my medical defence organisation/insurer to verify that I maintain appropriate medical indemnity coverage for the Scope of Practice sought.
- ☐ I authorise, if applicable, Albany Day Hospital to request a criminal history check be carried out on me.
- ☐ I declare that the statements contained in this application are correct. In applying for appointment I agree to abide by Albany Day Hospital policies and regulations and any terms or conditions which are attached to my appointment by the credentialing committee.
- ☐ I undertake to immediately notify the CEO or Chair of Credentialling Committee of any material changes to the information provided by me in connection with this application, as soon as possible after the change, and particularly if my clinical Privileges are retracted, withdrawn or altered at any other hospital or day procedure facility.
- ☐ I authorise Albany Day Hospital, its officers and agents to seek information as to my past experience, performance and current fitness and the validity of my responses to the above questions.
- ☐ I understand that I may be granted Interim Clinical Accreditation and Scope of Practice until I receive notification of full Clinical Accreditation following the next Credentialling Committee Meeting.
- ☐ I am aware that I will have to complete a Reapplication of Clinical Accreditation and Defining Scope of Practice form when notified of my impending expiration of my current term of Clinical Accreditation at Albany Day Hospital.
- ☐ I understand that if I have provided misleading or deceptive information which is likely to mislead or deceive, that the Albany Day Hospital Medical Advisory Committee or Montserrat Board may (at its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.
- ☐ I acknowledge that I have been provided with, and read a copy of the Hospital By-Laws and Credentialling Policy. If appointed I agree to abide by the policies, procedures of the Hospital's Medical By-Laws.

Signed:.....

Date: .....

Witness Signature: .....

Witness Name: .....

(Please use block letters)

Applicant Checklist

Please ensure that all items are included in/with your application

- ☐ Curriculum Vitae
- ☐ Evidence of Experience and ongoing Education within your Scope of Practice in ADH/BDH
- ☐ Copy of Photo Identification
- ☐ Required evidence of competency (as indicated in privileges sought)
- ☐ Documentation in relation to "FALSE" answers in the 'Applicant's Declaration' (Pages 4 & 5)
- ☐ Evidence of current Indemnity Insurance membership
- ☐ Contact details of at least 3 referees
- ☐ Applicants Declaration
- ☐ Signed and Witnessed Statement of Acceptance

Application for Clinical Accreditation and Defining Scope of Clinical Practice

OFFICE USE ONLY

Applicant Name: .....

Discipline: .....

Scope of Practice:

.....

.....

.....

	Checked (☐)
1. Contact details provided	☐
2. CV	☐
3. Photo ID	☐
4. Qualifications	☐
5. Training and experience	☐
6. Clinical appointments	☐
7. Evidence of clinical medical education/professional development	☐
8. Medical Indemnity Insurance (Evidence provided)	☐
9. Documentation in relation to "FALSE" answers in the Declaration.	☐
10. Provider Number (if applicable)	☐
11. Specialist status	☐
12. Referees	☐
13. Peer review	☐
14. Google search completed; Surname, First name, Disciplinary action	☐
15. Declaration signed	☐
16. Statement of Acceptance signed	☐

17. Other comments

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.....

.....

Signature: _____

Date: _____

OFFICE USE ONLY

Applicant Name: .....

Scope of Clinical Practice: .....

Applicant's details checked by (name) .....

Signature ..... Date:.....

References Checked by (name) .....

Signature ..... Date:.....

Peer Review Conducted by (name): ..... Specialty: .....

Signature ..... Date:.....

Peer Review Recommendation: Approved ☐ Rejected ☐

Comments: .....

.....

Interim Accreditation granted by: …….. Start: …… End …….

Application: Endorsed ☐ NOT Endorsed ☐

If Application rejected, detail reasons:

.....

.....

.....

Full Endorsement of Credentialling by Committee at its meeting on (date) ……..

Letter to applicant advising outcome of application **YES** ☐

Copy provided in electronic file **YES** ☐

Credentialling Register updated with Doctor credentialing, insurance and registration details **YES** ☐

Please note: the Chair of the Credentialling Committee or CEO only may confirm granted Interim Privileges