TOWNSVILLE DAY SURGERY CREDENTIALING AND SCOPE OF PRACTICE APPLICATION FORM (QLD)

Private and Confidential

APPLICATION FOR APPOINTMENT AND SCOPE OF CLINICAL PRACTICE AS AN ACCREDITED PRACTITIONER

PLEASE PRINT OR TYPE, TICK RELEVANT BOXES, AND SIGN THE FORM.
PLEASE RETURN THE FORM WITH A COPY OF YOUR CURRICULUM VITAE, PROOF OF REGISTRATION AND PROFESSIONAL INDEMNITY TO:

Townsville Day Surgery
1 Martinez Avenue
West End Qld 4810

Telephone: 07 4725 4500
Facsimile: 07 4725 4566
Email: reception@townsvilledaysurgery.com.au

NEW APPLICATION

PERSONAL AND CONTACT INFORMATION			
Surname		**Given Names**	
Preferred Title (e.g. Dr, Mr, A/Prof; Prof)		**Preferred Name**	
Any former names, including maiden name		**Date of Birth**	
Home Address ✉ preferred mailing address ❑	PCode	**Phone (home)**	
		Mobile Phone	
		Pager	
		Facsimile	
Email (personal)		**Email (business)**	

Emergency Contact Person		**Relationship**	
Phone (work) **Phone (mobile)**		**Phone (home)**	

Provider Number		**Prescriber Number**	

Name of Partner/ Spouse (for Hospital invitation list)	

PROFESSIONAL PRACTICE DETAILS			
Practice Name (1)			
Business Address (Primary Consulting Room) ✉ preferred mailing address ❑	PCode	**Phone**	
		Facsimile	

Practice Name (2)			
Business Address (Other Consulting Rooms) ✉ preferred mailing address ❑	PCode	**Phone**	
		Facsimile	

PROFESSIONAL REGISTRATION DETAILS (Please attach copy of your Registration certificate)			
Registration Number		**Expiry Date**	
Category of Registration			

Are there any conditions or undertakings currently attached to this registration? Yes ❑ No ❑
If yes, please give details.

Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board, dental board or other registration board (as appropriate)? Yes ❑ No ❑
If yes, please give details of the restriction and what period during which the restrictions apply/applied.

PROFESSIONAL INDEMNITY (Please attach copy of your professional indemnity certificate)			
Indemnity Insurance Number		**Category of Coverage**	
Insurance Company			

Does your membership fully cover the scope of clinical practice you have applied for? Yes ❑ No ❑

Has your medical defence insurer or any medical defence insurer or fund of which you have been a member ever applied conditions or refused to renew your cover or membership (in part or in full)? Yes ❑ No ❑
If yes, please provide details.

Are there any current claims for compensation against you or complaints lodged with the Medical Board (or other Registration Board) or Health Quality & Complaints Commission (HQCC)?
Yes ❑ No ❑
If yes, please provide details.

Have there ever been any adverse findings made against you which would be relevant to your appointment (for example: breach of insurance/medical laws, professional misconduct, sexual assaults or assault) by the Health Insurance Commission, a Medical or Registration Board, a Health Care Complaints Commission/Body, a Coroner, a Court or any other negligence, professional, disciplinary or similar body?
Yes ❑ No ❑
Criminal Record Check – Have you been convicted of, or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)?
Yes ❑ No ❑
If yes, and if not prevented by confidentiality agreements, could you please provide a brief description of each adverse judgement or settlement, and the year in which the event occurred?

* This information is required to assess an application for scope of clinical practice and will only be used by Townsville Day Surgery for such purposes. Information provided will not be disclosed otherwise.

Please nominate a Medical Practitioner accredited at the Hospital in your Specialty available for contact by the Hospital in the case of an emergency if you are unavailable, and who has agreed to deputise for you.

Name	
Specialty	
Contact Number	

CLINICAL PRACTICE SOUGHT IN THE FOLLOWING CATEGORY(S) (Please tick)

- ❑ Specialist Medical Practitioner
- ❑ General Medical Practitioner
- ❑ Pharmacist
- ❑ Locum Tenens
- ❑ Dental Practitioner
- ❑ Surgical Assist (no admit rights)
- ❑ Allied Health Professional
- ❑ Employed Medical Officer
- ❑ Nurse Practitioner
- ❑ Registered Nurse (employed by VMO)
- ❑ Registered Nurse working in specialised area

PRIVILEGES SOUGHT (Please tick)

- ❑ Admitting
- ❑ Consulting
- ❑ Surgical Assist
- ❑ Anaesthetic
- ❑ Sedation (GP Only)
- ❑ Surgical
- ❑ Surgical (RN Only)
- ❑ Procedural
- ❑ Allied Health
- ❑ Nursing Assessment & Patient Education
- ❑ Contract of Employment (Employed Medical Officers)
- ❑ Contract of Employment (Employed Allied Health Professional)

DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED: (Not applicable to Surgical Assistants) (Please tick)

- ❑ Anaesthesia
  - ❑ Adults
  - ❑ Cardiac
  - ❑ Neonatal
  - ❑ Obstetric
- ❑ Other _____
- ❑ Cardiac Surgery
  - ❑ Adult
- ❑ Dental
  - ❑ Oral & Maxillofacial
- ❑ Dermatology
  - ❑ Adult
- ❑ Emergency Medicine
  - ❑ Adult
- ❑ Endocrinology
  - ❑ Adults
- ❑ ENT Surgery
  - ❑ Adult
  - ❑ Head and Neck
- ❑ Gastroenterology
  - ❑ Endoscopy
  - ❑ Other _____
- ❑ General Surgery
  - ❑ Adult
  - ❑ Endoscopy
  - ❑ Laparoscopic Surgery
  - ❑ Other _____
- ❑ Neurosurgery
  - ❑ Adult
- ❑ Nuclear Medicine
- ❑ Gynaecology
  - ❑ Gynaecology General
  - ❑ Uro-gynaecology
  - ❑ Ultrasound
  - ❑ Advanced Endoscopic Surgery
  - ❑ Laparoscopic Surgery
  - ❑ IVF
  - ❑ Other _____
- ❑ Ophthalmology
  - ❑ Adult
- ❑ Oral & Maxillofacial Services
  - ❑ Facio Maxillary Surgery
- ❑ Orthopaedics
  - ❑ Adult
  - ❑ Other _____
- ❑ Palliative Care
- ❑ Physicians/Internal Medicine
  - ❑ Clinical Haematology
  - ❑ General Medicine
  - ❑ Geriatrics
  - ❑ Medical Oncology
  - ❑ Neurology
  - ❑ Nephrology
  - ❑ Respiratory
  - ❑ Rheumatology
  - ❑ Other _____
- ❑ Plastic & Reconstructive Surgery
  - ❑ Adults
- ❑ Psychiatry
  - ❑ Sub Specialty specify: _____
  - ❑ ECT
  - ❑ CYMH
- ❑ Medical Imaging
  - ❑ Adult
  - ❑ Radiation Oncology
  - ❑ Other _____
- ❑ Rehabilitation Medicine
- ❑ Urology
  - ❑ Adult
  - ❑ Other _____
- ❑ Vascular Surgery
- ❑ Thoracic Surgery
  - ❑ Adult

OTHER CLINICAL PRACTICE SOUGHT (Not applicable to Surgical Assistants)

FIELD	Surgical Admitting	Medical Admitting	Consulting	Other (Specify)
	❑	❑	❑	❑

REFEREES

For each major specialty in which you are seeking clinical practice, please provide names, addresses, telephone numbers, facsimile numbers and email addresses of three (3) professional referees (at least one from your own profession) who can attest to your recent practice and have known you for at least 12 months within the past 3 years. We prefer (where possible) that these referees are independent. However, where there is a relationship which may lead to a bias, such as a referee and the applicant are in business together as a partnership, or are employer/employee, then this relationship must be disclosed by you to the hospital. Please note that your referees will be contacted and asked to provide a reference. The reference should be in writing.

Specialty			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

Specialty			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

PRIMARY UNDERGRADUATE QUALIFICATION (List below or attach CV)

Name of University/ Institution	Degree/s	Graduation Year

POSTGRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS, COLLEGE OR PROFESSIONAL QUALIFICATIONS (List below or attach CV – copies of qualification/s to also be attached)

Qualification	Date Obtained	Accredited Training Organisation

PROFESSIONAL DEVELOPMENT OVER PAST 3 YEARS - Please include any research activities, funded projects and quality assurance activity. (List below or attach CV)

CURRENT PUBLIC HOSPITAL APPOINTMENTS (List below or attach CV)

Hospital	Appointment

CURRENT SCOPE OF CLINICAL PRACTICE AT OTHER PRIVATE HOSPITALS (List below or attach CV)

Hospital	Appointment

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

Yes ❑ No ❑

If yes, please provide the name of the facility and rationale for refusal. *Please note a senior executive of the Hospital may contact the facility.*

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 give dates and particulars. *Please note a senior executive of the Hospital may contact the facility*

DETAILS OF ALL HEALTH CARE RELATED EMPLOYMENT WITHIN THE LAST 10 YEARS (List below or attach CV)

Hospital	Appointment

SPECIAL PROFESSIONAL INTERESTS

PROFESSIONAL AFFILIATIONS

Are you a member of any Specialist College(s)/Association(s)? (If yes, please provide details) Yes ❑ No ❑

PUBLICATIONS (List below or attach CV)

NOTE: COPIES OF THE FOLLOWING MUST ACCOMPANY THIS APPLICATION:

- ❑ **CURRICULUM VITAE**
- ❑ **EVIDENCE OF QUALIFICATIONS AND PARTICIPATION IN CONTINUING MEDICAL EDUCATION**
- ❑ **PROOF OF REGISTRATION**
- ❑ **PROFESSIONAL INDEMINITY – CERTIFICATE OF CURRENCY**

DECLARATION AND AUTHORITY

I authorise the Townsville Day Surgery, its employees, officers and the Medical Advisory Committee, 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.

Specialist Directory
I authorise the Townsville Day Surgery to include my practice details in any Hospital Specialist Directory. Yes ❑ No ❑

I authorise Townsville Day Surgery to conduct a criminal record check in respect of my history including information relevant to the provision of services to children and I agree to notify the Chief Executive Officer if I am convicted of a sex or violence offence or any other offence relevant to my practice as a Medical Practitioner.

I authorise the Townsville Day Surgery, its officers and the Medical Advisory Committee 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.

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 order to enable me to exercise that scope of clinical practice safely and competently. I undertake to notify the Townsville Day Surgery if this statement becomes incorrect in the future.

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.

I declare that I am the person named in this application 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. I understand that if I have provided misleading or deceptive information, or information which is likely to mislead or deceive, that the Townsville Day Surgery Board may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.

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 of the Townsville Day Surgery, including any annexure or variation to the By-Laws during the tenure of my appointment, all relevant legislative requirements (including compliance with HQCC Standards) and any terms and conditions which are attached to my appointment by the Board/Licensee. I understand that non-compliance with the Hospital By-Laws may be grounds for suspension, termination or imposition of conditions on my clinical privileges.

I undertake to notify the Townsville Day Surgery promptly and in writing, if my scope of clinical practice is altered in any way at any other hospital or day procedure centre.

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 activity including submitting my practice to clinical audit and peer review, in conjunction with the hospital, the Medical Advisory Committee or clinical specialty committees if required by Townsville Day Surgery.

I undertake to notify Townsville Day Surgery should any information provided in this application for appointment vary in any way

I acknowledge and agree to release and indemnify Townsville Day Surgery 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.

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 Chief Executive Officer or duly authorised person.

I understand that my Appointment will be reviewed in three (3) years or earlier if considered necessary.

SIGNATURE _____ DATE _____/_____/_____

WITNESS NAME _____ WITNESS SIGNATURE _____ DATE _____/_____/_____

CONSIDERATION OF ACCREDITED PRACTITIONER APPLICATION FOR APPOINTMENT FORM

OFFICE USE ONLY

PRACTITIONER NAME: _____ **PROVIDER NUMBER** _____

APPLICATION FORM COMPLETED & CV RECEIVED Y ❑ N ❑	DATE:	**PRIVILEGES GRANTED**	**DATE**
Copy of Registration Received Y ❑ N ❑	Date:	Approved by Licensee as evidenced by the letter sent on behalf of the Licensee, confirming the appointment	
Copy of certificate of currency for Medical Indemnity Insurance received. Y ❑ N ❑	Date:	Applicant Notified	
Copy of Post Graduate Qualifications and Copy of College Fellowship Received Y ❑ N ❑	Date:	Application entered into Hospital IT Management System	
Copy of certificate showing participation in Continuing Medical Education (where available) Y ❑ N ❑	Date:	Registration/Insurance Renewal Dates noted	
Relevant References Received Y ❑ N ❑ References Reviewed Y ❑ N ❑	Date: Date: Name of Reviewer:	Date for re-application	
Recommended by Credentialling Committee	Name of Peer Reviewer: Date: Signature:	Date of withdrawal from list	
Recommended by Medical Advisory Committee	Date: Signature:		
Recommended by Chief Executive Officer	Date: Signature:		

Note: This page is to be circulated with the MAC Agenda and a copy attached to the minutes of the Medical Advisory Committee meeting at which the application is approved. The completed original of this form should remain with the complete application.