



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:

Emma Morgan
Townsville Day Surgery
1 Martinez Avenue
West End Qld 4810

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

NEW APPLICATION

PERSONAL AND CONTACT INFORMATION			
Surname		Given Names	
Preferred Title <small>(e.g. Dr, Mr, A/Prof; Prof)</small>		Preferred Name	
Any former names, including maiden name		Date of Birth	
Home Address <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	PCode	Phone (home)	
		Mobile Phone	
		Pager	
		Facsimile	
Email (personal)		Email (business)	
Emergency Contact Person		Relationship	
Phone (work)		Phone (home)	
Phone (mobile)			
Provider Number		Prescriber Number	
Name of Partner/ Spouse <small>(for Hospital invitation list)</small>			
PROFESSIONAL PRACTICE DETAILS			
Practice Name (1)			
Business Address <small>(Primary Consulting Room)</small> <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	PCode	Phone	
		Facsimile	
Practice Name (2)			
Business Address <small>(Other Consulting Rooms)</small> <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	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? If yes, please give details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
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)? If yes, please give details of the restriction and what period during which the restrictions apply/applied.			Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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)? If yes, please provide details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
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)? If yes, please provide details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
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? 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)? 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?			Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
* 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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Specialist Medical Practitioner | <input type="checkbox"/> Dental Practitioner | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> General Medical Practitioner | <input type="checkbox"/> Surgical Assist (no admit rights) | <input type="checkbox"/> Registered Nurse (employed by VMO) |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Allied Health Professional | <input type="checkbox"/> Registered Nurse working in specialised area |
| <input type="checkbox"/> Locum Tenens | <input type="checkbox"/> Employed Medical Officer | |

PRIVILEGES SOUGHT (Please tick)

- | | | |
|--|---|---|
| <input type="checkbox"/> Admitting | <input type="checkbox"/> Surgical | <input type="checkbox"/> Nursing Assessment & Patient Education |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Surgical (RN Only) | <input type="checkbox"/> Contract of Employment (Employed Medical Officers) |
| <input type="checkbox"/> Surgical Assist | <input type="checkbox"/> Procedural | <input type="checkbox"/> Contract of Employment (Employed Allied Health Professional) |
| <input type="checkbox"/> Anaesthetic | <input type="checkbox"/> Allied Health | |

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

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

OTHER CLINICAL PRACTICE SOUGHT (Not applicable to Surgical Assistants)

FIELD	Surgical Admitting	Medical Admitting	Consulting	Other (Specify)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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 INDEMNITY – 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 ____/____/____