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

Private and Confidential

NEW APPLICATION ❑ RENEWAL APPLICATION ❑

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 AND ALL SUPPORTING DOCUMENTATION TO:

Credentialing Officer
Townsville Day Surgery
1 Martinez Avenue
West End Qld 4810

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

If you are submitting this application within two (2) weeks of your intended start date, please contact the hospital's Credentialing Officer on (07) 4725 4500 to ensure your application has been received for processing.

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 ❑		**Phone (home)**	
		Mobile Phone	
		Facsimile	
Email (personal)		**Email (business)**	

EMERGENCY CONTACT PERSON			
Name		**Relationship**	
Phone (work)		**Phone (home)**	
Phone (mobile)			
Name of Partner/ Spouse (for Hospital invitation list)			

PROVIDER DETAILS			
Provider Number		**Prescriber Number**	

INDENTIFICATION CHECK – 100 POINTS OF IDENTIFICATION REQUIRED	
Please attach copies of the following to this application ensuring they meet the 100 points of identification	
Drivers Licence (60 Points) ❑	**Birth Certificate (50 Points)** ❑
Passport (50 Points) ❑	**Medicare Card (40 Points)** ❑

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Author: Facility Manager
Authorised by: MAC
Referenced in: Management Policy 2.0021

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

Practice Name (2)			
Business Address (Other Consulting Rooms) ✉ preferred mailing address ❑		**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**	
Insurer Name		**Expiry Date**	
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 against you with your insurer, Medical Board (or other Registration Board) or Office of the Health Ombudsman (OHO)?

Yes ❑ No ❑

If yes, please provide details.

MEDICO LEGAL*

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 OHO, 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?

Immunisation History Check – Townsville Day Surgery requires each new applicant to provide a copy of their Immunisation History Statement (or alternatively Serology results). **(Please attach copy of your Immunisation History Statement)**

* 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.

IN CASE OF EMERGENCY – DEPUTY MEDICAL OFFICER

Please nominate a Medical Practitioner, **accredited at the hospital in your specialty**, who has agreed to deputise for you. The Medical Practitioner must be available for contact by the Hospital in the case of an emergency if you are unavailable.

Name of Accredited Nominee	
Specialty	
Contact Number (Mobile)	

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

❑ Specialist Medical Practitioner	❑ Fellow Medical Practitioner	❑ Dental Practitioner
❑ General Medical Practitioner	❑ Locum Tenens	❑ Surgical Assistant (no admit rights)

PRIVILEGES SOUGHT (Please tick)		
❑ Admitting	❑ Anaesthetic	❑ Procedural
❑ Consulting	❑ Sedation (GP)	
❑ Surgical Assist	❑ Surgical	

DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED - NOT APPLICABLE TO SURGICAL ASSISTANTS (Please tick)

❑ **Anaesthesia**
- ❑ Sedation Only
- ❑ Other _____

❑ **Dental Assistant**

❑ **Dental Practitioner**

❑ **Gastroenterology**
- ❑ Endoscopy
- ❑ Other _____

❑ **General Surgery**
- ❑ Endoscopy
- ❑ Laparoscopic
- ❑ Colorectal
- ❑ Other _____

❑ **Gynaecology**
- ❑ Gynaecology General
- ❑ Uro-gynaecology
- ❑ Ultrasound
- ❑ Advanced Endoscopic
- ❑ Laparoscopic
- ❑ IVF
- ❑ Other _____

❑ **Medical Imaging**
- ❑ Endoscopy
- ❑ Other _____

❑ **Ophthalmology**
- ❑ Other _____

❑ **Orthopaedics**
- ❑ Other _____

❑ **Pain Management**
- ❑ Other _____

❑ **Plastic & Reconstructive**
- ❑ Other _____

❑ **Registered Nurse**

❑ **Supporting Personnel**
- ❑ IVF Scientist
- ❑ Medical Scribe
- ❑ Other _____

❑ **Surgical Assistant**

❑ **Urology**
- ❑ Other _____

❑ **Vascular**
- ❑ Other _____

OTHER CLINICAL PRACTICE SOUGHT (Not applicable to Surgical Assistants)

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

This section has been left intentionally blank

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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 **written reference**.

Name (Referee 1)			
Address			
Phone		Facsimile	
Email Address			

Name (Referee 2)			
Address			
Phone		Facsimile	
Email Address			

Name (Referee 3)			
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 Hospital Management member 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 Hospital Management member may contact the facility.*

Have you ever been disciplined, undergone or been required to take (remedial or otherwise) a program, course or therapy for workforce, professional or personal behaviour related to your practice, or to your credentials at a health facility? Yes ❑ No ❑

If yes, please give dates and particulars. *Please note a Hospital Management member 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:

- ☐ Current CV
- ☐ Proof of Identity Documents
- ☐ Registration Certificate
- ☐ Indemnity Insurance
- ☐ Covid Vaccination Statement (if applicable)
- ☐ Immunisation History Statement
- ☐ Post Graduate Qualifications and copy of College Fellowship (if applicable)
- ☐ Most recent CPD Certificate from your College
- ☐ Signed copy of the Clinicians Code of Conduct
- ☐ Mandatory Training:
  - **HAND HYGIENE -** https://nhhi.southrock.com/cgi-bin-secure/Home.cgi
    (Certificate from another hospital or education program acceptable)

DECLARATION AND AUTHORITY

I authorise the Townsville Day Surgery to release my contact details, including mobile phone number, to other VMO's that currently hold clinical privileges at Townsville Day Surgery:

Yes ❑ No ❑

I authorise Townsville Day Surgery Pty Ltd ('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.

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 Facility Manager or duly authorised person if I am convicted of a sex or violence offence or any other offence relevant to my practice as a Medical Practitioner.

I authorise 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 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 Medical Practitioners By-Laws.

I declare that my personal immunisation status is current for preventable diseases. I declare that I will continue to maintain the appropriate immunisation status for the duration of my clinical privileges.

In applying for appointment I acknowledge that I have been provided with, and read, a copy of the Medical Practitioners By-Laws and if appointed, agree to abide by the Medical Practitioners By-Laws and policies of the Townsville Day Surgery, including any annexure or variation to the Medical Practitioners 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. I understand that non-compliance with the Medical Practitioners By-Laws may be grounds for suspension, termination or imposition of conditions on my clinical privileges.

I undertake to notify 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 Medical Practitioners 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 Manager or duly authorised person.

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

NAME_____ SIGNATURE _____ DATE _____/_____/_____

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

1. Document Controls

1.1 Related Policy Documents:

	Document
2.0006	Medical Practitioners By-Laws
5.0000c	Professional Code of Conduct Clinicians

1.2 Document Revision History:

Version	Release Date	Amendment(s)	Risk-Rated Review Date
1.0	01/12/2008	Original Version	01/12/2009
1.1	01/12/2009	Review	01/12/2013
1.2	01/12/2013	Review	01/12/2016
1.3	01/12/2016	Review	01/12/2019
1.4	01/12/2019	Review	01/12/2022
1.5	01/12/2022	Review	01/12/2024
2.0	10/01/2024	Review to align with updated Medical Practitioners By-Laws and consolidated renewal application form within	10/01/2026
2.1	01/03/2024	Minor Amendment	10/01/2026

1.3 Document Review and Approval:

Name (Position/Committee)	Function (Owner/Author/Review/Approve)
Facility Manager	Owner/Author/Review
Medical Advisory Committee	Review
TDS Board	Approve