Application for appointment and scope of practice as an accredited Practitioner

NEW APPLICANT

1. Application for scope of clinical practice

I wish to apply to undertake a scope of practice for

_____

(For example, surgeon, anaesthetist, dentist, assistant).

Sir John Monash Private Hospital will verify medical registration via the website.

2. Applicant contact details

Surname_____

Given name(s) _____

Previous name (s) if applicable _____

Date of birth Place of birth

Professional address

Postcode

Postal address *(if different to professional address above)*

_____Postcode_____

Phone (BH)_____ Phone (AH)_____

Fax_____ Mobile/pager_____

Email address

Do you have a Medicare provider number for this location? Yes No

Number:_____

If YES, is it subject to any restrictions? Yes No

If restrictions apply, please provide full details.

_____

Do you have a prescriber number? Yes No Prescriber Number:_____

3. All qualifications including your primary medical degree

Please list all your qualifications.
Please provide **certified copies** of new qualifications obtained.

Qualifications	University/organisation	Year obtained
Primary medical degree		
Others		

4. Speciality Information

Primary Speciality	Sub-speciality or area of special interest *(if applicable)*
Please outline scope of clinical practice sought including where relevant, the type of procedures you wish to undertake: (please use additional pages if required	
Please detail relevant clinical experience & post qualification training if not already listed in Section 3.	

5. Clinical appointments

Please provide details on all current and previous clinical appointments held within the past five years (including names of organisations and dates of appointment) or other places of practice
(for example, general practice, other hospitals or non-public-hospital-based specialty practice).

Organisation	Name and type of appointment	Dates
		to
		to
		to

6. Medical registration and other matters

Please refer to < www.ahpra.gov.au> for definitions.

What is your Australian Health Practitioners Regulatory Association number?	
Is this *general* registration?	Yes No
Is this *specialist* registration?	Yes No If yes, please specify
Is this *limited* registration?	Yes No If yes, please specify: Area of need Public interest Teaching or research
If you have *limited* registration, and/or you are to be supervised or under a college peer-review process, please provide details of this process.	

Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a medical practitioner?	Yes No
Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board either in Australia or elsewhere?	Yes No
Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country?	Yes No
Have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration either in Australia or elsewhere?	Yes No
Have you ever been denied a scope of clinical practice that you requested?	Yes No
Have you ever chosen to reduce your scope of practice?	Yes No
Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	Yes No
Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?	Yes No
Are you the subject of current or pending criminal charges?	Yes No
If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'Confidential for Chair of the MAC only' appended to this application, and indicate here that additional information is provided separately in this manner.	

7. Medical indemnity insurance information

Current private medical indemnity insurance cover (if applicable). **Please attach a certified copy.**	Name of insurer: Policy number: Expiry date:
Is your proposed scope of private clinical practice reflected in or covered by your current medical indemnity insurance?	Yes No N/A
Have there ever been, or are there currently pending, medical indemnity claims, settlements or judgements against you?	Yes No
Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	Yes No
If the answer to either of the above two questions is YES, please provide a detailed explanation and specify the name of the relevant medical defence organisation/insurer.	

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

8. Continuing professional development

Provide a copy of your current college certificate, annual statement of participation or evidence of relevant continuing professional development (such as a CPD logbook).

Have you met the continuing professional development requirements for AHPRA? Refer to AHPRA's registration standard for details at < www.medicalboard.gov.au/Registration-Standards.aspx> .	Yes No

9. Health status

Do you have a disability or health issue that: • may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application? • may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application? • may be relevant to determining your scope of practice? If you answered YES, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included. This information can be provided on this form or, alternately, you can provide the information in a sealed envelope marked 'Confidential for Chair of MAC only' appended to this application. Indicate here if additional information is being appended. This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure you can work at the health service in a way that ensures patient safety.	Yes No

10. Referees

Please provide details of two referees who preferably work largely within the specialty being applied for, who have been in a position to judge your experience and performance during
the previous three years and who have no conflict of interest in providing a reference.

Referee 1

Name		
Current position		
Professional address		
Phone (BH)		Phone (mobile)
Email address		

Referee 2

Name		
Current position		
Professional address		
Phone (BH)		Phone (mobile)
Email address		

11. Agreement/undertakings

I understand that in assessing my application for appointment as a medical practitioner the health service will make additional enquiries as to my suitability for the position.

I authorise the health service to seek information from my referees as to my past experience, performance and current fitness to practise.	Yes No
I agree to familiarise myself with relevant hospital by-laws, policies and	Yes No

procedures and to abide by them.	
I accept that the health service will obtain information relevant to my application from the Medical Board of Australia and any other authority that regulates health practitioners.	Yes No
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	Yes No
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes No
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes No
I agree to abide by the organisations and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes No
I agree to notify the CEO of any event/situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the Chair of MAC would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).	Yes No
I agree to participate in this health service's performance development and support process (ISO 9001 and NSQHSS requirements).	Yes No
I agree to promptly notify CEO of any adverse clinical incident I am involved in, or become aware of.	Yes No
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes No
Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	Yes No

12. Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant	Date

If, for any reason, you are unable to sign the declaration above, please explain the circumstances.

Please note: the information collected on this form will be used by the Sir John Monash Private Hospital MAC to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

Sir John Monash Private Hospital operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of Sir John Monash Private Hospitals' privacy and confidentiality policies are available upon request to the CEO.

Please attach the following to this form

- Proof of identification: 100-point test
- National police history check
- International police check if the applicant has lived overseas for 12 months or longer in the past 10 years
- Copy of Working with Children Check
- **Certified copy** of primary medical degree and a certified translation when not in English
- **Certified copy** of specialist qualifications and a certified translation when not in English
- **Certified copy** of current medical indemnity insurance certificate
- Current curriculum vitae
- Evidence of Continued Professional Development

100 points – verification details

Type of check	Available points	Notes
Passport (current or expired by less than two years, not cancelled) Citizenship certificate (Australian only) Birth certificate (original or extract) Birth card issued by the Victorian	70	Must contain name and a photo. Select one only.

Registry of Births, Deaths and Marriages		
Written reference Written reference from an acceptable referee from a financial institution	40	Select one only. Referee to have known the signatory for at least 12 months. Both signatory and referee must sign the reference.
Driver's licence. Renewed, interim, provisional, truck or learner's Other acceptable government-issued licences include boat, gun or pilot Public Service Employee Identification Card Pension or government Health Care Card (reference number required) Identification card issued by a tertiary education institute	40 40 40 40 40	Must contain name, expiry date, a photo or signature.
Letter from a current employer (current or must have been employed by the employer within the past two years)	35	Must be on letterhead or company seal. Both employer and employee's signature must be on the letter, along with the name and address of the employee.
Medicare card Overseas or international driver's licence or Proof of Age card	25 25	
Financial institution's credit card, cash card or passbook	25	Only one current card/passbook can be accepted from each financial institution. You may supply details from several different institutions but cannot solely rely on this form of identification.
Type of check	Available points	Notes

Rating authorities Rate notice (current). Provide the deposited plan (DP) number	35	
Public utility (water rate notice, electricity, gas or telephone account – no mobile accounts). Take a *current* notice with you.	25	
Statement from landlord, managing agent or owner of customer premises	25	Take letter, rental contract or rent receipt with you.

Office use only

Item	Checked/comments
1. Proof of identification	
2. Contact details provided	
3. Provider number	
4. Prescriber number	
5. C.V	
6. Qualifications (primary & specialist)	
7. Training and experience	
8. Clinical appointments	
9. Medical registration	
10.Medical indemnity cover currency	
11.Continuing professional development	
12. Working with Children Check	
13.National/International Police Check	
14.Health status	
14.Referees	
16.Declaration signed	
Application details checked by DON	Date:
Letter to applicant advising outcome of application	Yes Copy attached

Review for permanent accreditation of 3 years

The above applicant has been approved for permanent accreditation for the next 3 years.

Medical Advisory representative (please circle appropriate specialty):

Anaesthetist Dental Oral/Maxillo Facial Surgeon

Name:_____

Signature:_____

Date:

Sir John Monash Private Hospital Chief Executive Officer:

Name: Anthony Bafunno

Signature:_____

Date:

Sir John Monash Private Hospital Director of Nursing:

Name: Joanne Adams

Signature:_____

Date:

Comment (if applicable):