



# WESTMINSTER DAY SURGERY

## MEDICAL / DENTAL APPLICATION FOR VISITING RIGHTS AND PRIVILEGES

476 Wanneroo Rd Westminster. WA 6061  
Phone: 9349 5555 Fax: 9344 1744  
Email: admin@westminsterdaysurgery.com

Please complete and return with a copy of: Curriculum Vitae – with Certified Copies of Degrees, & Professional Qualifications.

Copy of Indemnity Insurance Receipt  
Copy of Medical/Dental Board of WA annual

registration

**PATIENT WEIGHT LIMIT** - Due to Health & Safety considerations, patients whose weight is greater than 130Kg cannot be treated at this hospital

• I wish to apply for accreditation and clinical privileges in:

Anaesthesia: General  Paediatric  Pain Management

Surgery: General  Paediatric  Orthopaedic  Gynaecology  Plastic Surgery

Dental  Ophthalmology  Endoscopic  Other \_\_\_\_\_

Specific Privileges requested: (please list surgical procedures.)

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Please state any procedure not normally considered part of your speciality you may be performing – Note evidence of further education and training must be provided.

### PERSONAL INFORMATION

Surname: .....

Given Names: ..... Date of Birth: .....

Practice Address: .....

..... E- Mail:.....

Phone: ..... Pager Number: ..... Mobile Phone: .....

Private Address:.....

Telephone:..... Silent Telephone Number:.....

### QUALIFICATIONS: Please include curriculum vitae

University & Qualifying Degree: (with dates):.....

Higher degrees / qualifications: (with dates)

.....

**REGISTRATION**

Are you registered as a practitioner with the **Medical/Dental** Board of WA? Yes No  
Medical/Dental Board of WA Registration Number (attach copy)

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Medical Defence organization: (attach copy of receipt-detailing level of coverage)

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**OTHER HOSPITAL APPOINTMENTS**

Current:.....

.....

Previous:.....

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**CLINICAL PRIVILEGES AND QUALITY**

Have your clinical privileges been suspended at any other facility? Yes No

Please provide details:.....

Are you currently under suspension? Yes No

Have you any criminal record or charges against you? Yes No

Have you subjected your clinical work to quality assurance mechanisms including clinical audit and peer review processes? Yes No

Are you prepared to subject your work to quality assurance mechanisms including clinical audit and peer review processes? Yes No

**INFECTION CONTROL**

Are you known to have any conditions likely to limit your physical activity and or result in transmission of infection to others?

If yes, provide details (refer to by-laws)

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.....

In the past 12 months have you worked or been admitted to a hospital overseas or in a state other than Western Australia?

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**REFEREES**

**Nominations of TWO Medical/Dental Practitioners as Referees:**

Name .....Mobile.....

Address: .....Phone No.....

Name: .....Mobile.....

Address.....Phone.No.....

**PRACTITIONER BACKUP**

Nomination of Medical/Dental Practitioners Backup:

The nominated practitioner must be prepared to act as a routine backup to you in the event of your non-availability in an urgent situation. You must advise the doctor accordingly as he/she may be required to be accredited as a matter of urgency. This should be expedited within 48hours

Name: ..... Contact Number Day:.....

Address:.....

Pager:..... Mobile: .....

**AGREEMENT**

- I agree to abide by the by-laws of the hospital as presently in force and as may from time to time be enacted.
- I hereby authorize the Hospital's Chief Executive Officer to confer or correspond with my referees with respect to my application for appointment as an Accredited Practitioner.
- I hereby authorize the Credentials Committee to seek information as to my past experience and performance as the Committee sees fit.
- I certify the above information is correct

**Signed** ..... **Date:** .....

Note: For Medical Practitioners, a Practitioners Provider Number is required for this facility

**APPLICATION- Office Use Only:**

Date Application received.....

Date presented to Medical Advisory Committee .....Recommended: YES NO

Signatures: ..... (Advisory Committee)

Signature: ..... (Chairman, Medical Advisory Committee)

Signature: ..... (Chief Executive Officer)

Date Applicant Advised: .....

**CHECKLIST**

- ✓ Certified copies of degrees and higher qualifications.
- ✓ C.V. included
- ✓ Copy of current Medical / Dental Board Registration
- ✓ Current copy of Indemnity insurance receipt- level of coverage for privileges requested.
- ✓ Notification of practitioner back-up

Version 4 Feb 06 C:/ My documents on E / Doctors / Accreditation Form

Compiled: C.Roberts

Authorised: M.A.C. Credentialing Committee

References: Credentialing and Defining the Scope to practice Handbook May 04

Standards Australia AS8000 W.D.S .By-laws Medical act 1984, Amendment Act 2000Medical Rules 1987

Hospital and Health services Act 1927