WESTMINSTER DAY SURGERY
ABN: 77668458627

Application for Accreditation as a Visiting Medical/Dental Officer or Allied Health Practitioner

I hereby apply to Westminster Day Surgery for credentialing for a five year period as a Visiting Medical/Dental Officer or Allied Health Practitioner. To support my application, I submit the following information (**Please print** and attach separate sheets if insufficient space):

1. PERSONAL DETAILS		
Professional Title		
Surname:		
Given names:		
Former names (including maiden name):		
Date of Birth:		
Residential Address:		
		Post Code:
Contact Numbers:	**Phone:**	**Mobile:**
	Fax:	**Pager:**
Email Address:		

2. PRACTICE DETAILS		
Practice Name:		
Main Practice Address:		
		Post Code:
Contact Numbers:	**Phone:**	**Fax:**
Email Address:		
Address for Correspondence:		

3. CLINICAL PRIVILEGES

i) SPECIALITY IN WHICH APPOINTMENT IS SOUGHT:

ii) CLINICAL PRIVILEGES REQUESTED (please tick as appropriate)**:**

- ☐ **Admitting**
- ☐ **Operating**
- ☐ **Anaesthetic**
- ☐ **Diagnostic (Imaging/Pathology etc)**

4. QUALIFICATIONS/CONTINUING MEDICAL EDUCATION (Please attach any relevant supporting documentation)

Degree/Fellowship	College/Organisation & Program	Date Completed

5. CURRENT APPOINTMENTS

Appointment/s	Scope of practice	Organisation	Time commitment

6. NOMINATION OF ALTERNATIVE PRACTITIONER IN EVENT OF EMERGENCY

In the event that I am unable to be contacted for a clinical emergency for patients, the person nominated as agreed to be contacted:

Name:		
Contact Numbers:	**Phone:**	**Mobile:**
Alternative Contact:		

7. REGISTRATION

Do you have current and unrestricted registration with the Australian Health Practitioner Regulation Agency (please circle as appropriate)? **Yes/No**

Registration Number:	
Medicare Provider Number:	

8. PROFESSIONAL INDEMNITY INSURANCE

Please note that by submitting this application you consent to a representative from Westminster Day Surgery contacting your medical defence organisation / insurer to verify that you maintain appropriate medical indemnity coverage for the privileges sought.

Do you have sufficient Medical/Dental Indemnity Insurance at the appropriate level (please circle as appropriate)**?** **Yes/No**

Please attach a copy of your Medical Insurance Policy/Schedule.

Insurance Provider:		**Membership Number:**	

9. IMMUNISATION STATUS

It is a requirement of the Health Department of WA that each Health Care Facility maintain a record of the immunisation status of staff involved in direct patient contact. To meet this requirement, we ask if you could provide us with evidence of immunisation for the following:

Hepatitis B, MMR, DTP, TB, Polio, Varicella, Influenza, MRSA

☐ Vaccination Evidence Sighted (office use only)

10. EVIDENCE OF MANDATORY TRAINING

It is a requirement under the Australian Quality and Health Commission for all medical practitioners to provide evidence of Mandatory Training on an annual basis at the facilities they operate at. To meet this requirement, we ask if you could provide us with evidence of training for the following:

Initial once only:

ANTT, Cultural Diversity, Aggression management, Infection prevention and management principles.

Initial and then <u>Annually</u>:

Hand Hygiene, Manual Handling, CPR

11. PREVIOUS PLACES OF WORK/INPATIENT

Have you ever been a patient or worked in a hospital outside Western Australia or overseas in the last twelve months (please circle as appropriate)? **Yes/No**

If yes, please give details:

12. DISCLOSURE

Do you consent to Westminster Day Surgery undertaking criminal record checks on you as required by law (please circle as appropriate)**? Yes/No**

13. REFEREES (please nominate two Medical/Dental Practitioners as Referees):

i) Name:		
Address:		
Contact Numbers:	**Phone:**	**Mobile:**
Email Address:		
ii) Name:		
Address:		
Contact Numbers:	**Phone:**	**Mobile:**
Email Address:		

14. APPLICANT'S DECLARATION I declare that all the following statements are **TRUE** or **FALSE** as indicated in the tick boxes below.	**TRUE**	**FALSE**
I have never been subject to an adverse finding or had conditions or undertakings attached to my registration by a Medical Board and I am not currently under investigation by a Medical Board.	☐	☐
My right to practise and/or scope of clinical practice is not under investigation and/or has never been denied, restricted, suspended, terminated or otherwise modified in or by any other health care organisation (including overseas organisations, health facilities, learned colleges or other official bodies).	☐	☐
A Medical Defence Union or Fund has never refused to renew my membership.	☐	☐
I am not aware of any data from patient records, clinical audit, peer review processes or quality activities which reflects adversely on the outcomes of my clinical practice.	☐	☐
I participate in the continuing medical education program, maintenance of professional standards program, or similar, of my College or Society and I am current with the requirements of that program. (Please attach written confirmation, certification or other supporting documentation provided to you by your College or Society).	☐	☐
With respect to 'subspecialty' practice (eg complex or invasive procedures) where the relevant Austral(as)ian College or Society makes explicit recommendations about minimum caseload to maintain competency, I certify that my practice is compliant with such requirements, recommendations or guidelines, averaged over the past 2 years.	☐	☐
I have no physical or other condition or substance abuse that may limit my ability to exercise the extension to scope of practice which has been requested.	☐	☐
I have not been subject to criminal investigation or conviction.	☐	☐
I do not have any criminal charges pending against me.	☐	☐
I have never been convicted of a drug or alcohol related offence.	☐	☐
Please comment below if you are unable to answer "True" to any of the above questions and attach any relevant documentation.		
I warrant and represent that information provided by me to Westminster Day Surgery in this application and in connection with the 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 Westminster Day Surgery Management may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-laws.		

I agree that I will notify the Director of Nursing at Westminster Day Surgery of any material changes to the information provided by me in connection with this application as soon as possible after the change.
I acknowledge that I have been provided with, and read a copy of the Day Surgery By-laws, Open Disclosure Policy, Admission Exclusion Policy, Patient Centred Care Policy, Partnering with Consumers Policy, Standard Based Precautions Policy, Aseptic Non Touch Technique Policy and Clinical Handover Schedule 8 Medications Policy, Antimicrobial Prescribing Policy and Patient Identification Policy and agree to abide by such policies and By-laws of Westminster Day Surgery. Additionally I am prepared to participate in the teaching, research and quality improvement activities of Westminster Day Surgery

Signature:		**Date**:
Witness Name:		
Witness Signature:		**Date**:

CHECKLIST.

Please ensure that this form is fully completed and that the following documentation is included, otherwise your application will be delayed.

Contact details of **referees as relevant to extension of scope of practice.**	☐
Evidence of current **APHRA registration** coverage as relevant to the extension of scope of practice (where applicable).	☐
Evidence of current **Professional Indemnity Insurance** coverage.	☐
Evidence of Immunisation Status.	☐
Evidence of Mandatory Training	☐
Copy of Current **CV**	☐

RETURN OF APPLICATION

Please return completed document and relevant evidence to Westminster Day Surgery via one of the following mechanisms;

Post to:	Westminster Day Surgery **476 Wanneroo Road** **Westminster WA 6061**	**Fax** to: 9344 1744
Email to**:**	admin@westminsterdaysurgery.com	