Application for Credentialing

Applicant and Contact Details

Surname	
Given Name (s)	Date of Birth / /
Residency Status (Australian citizen /permanent/temporary resident)	
Professional Address	Postcode
Phone	Mobile
Email address	
Postal address (if different to Professional address above)	Postcode
Home address	Postcode

New appointments – credentialing requirements checklist

Please provide:

- Proof of identity based on 100 point check of original documents
- National Police History Check
- International Police History Check- *for applicants that have lived overseas for 12 months or longer during the past 10 years*
- Working with Children Check
- Employment history – current curriculum vitae (CV) that includes any relevant clinical and/or academic appointments; quality activities
- Referee contact details – appropriate referees who work largely in the specialty of the applicant, and are sufficiently able to judge the applicants experience and performance
- Original or certified copies of qualifications, including primary degree – *a certified translation if document not in english*
- Procedural qualifications (where applicable)
- Other evidence of training and clinical experience, as applicable
- Evidence of current compliance with all maintanance of professional standard requirements as determined by specialty colleges
- Continuing Professional Development (CPD) statements or certificates that are college approved or relevant to the scope of clinical practice
- Duty of Candour Certificate
- Hand Hygiene certificate - *current*
- Basic Life Support (BLS) certificate - *current*
- Vaccination Status per annum (Influenza)

Note: applicant will have medical registration confirmed prior to credentialing with the Specialist Surgicentre, including current Medical Board of Australia (AHPRA) registration; confirmation or absence of conditions, undertakings, endorsements, notations and reprimands; confirmation of the type of registration (eg general or specialist).

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1. **Application re-clinical scope of practice:**
   Copy of your current CV

Original or certified copy of qualification, including the primary medical degree. Certified translation when not in English

Position/classification sought e.g. surgeon, anaesthetist, podiatric, fertility, dental, etc

2. **Specialist qualifications**

Original or certified copy of specialist qualifications. Certified translation if not in English
Procedural qualifications (where applicable)

Qualification	***University/Organisation***	***Year Obtained***

4. Other evidence of training and clinical experience

Where relevant, include the title of course/s undertaken, the organisation offering the course, and the qualification obtained. Please provide copies of relevant qualifications. **DENTISTS**: **Surgairtome competence.** If you wish to use the surgairtome, are you skilled and experienced? How many cases have you used the surgairtome?

5. Evidence of current compliance with all maintenance of professional standard requirements as determined by the specialty colleges.

Clinical appointments

a) Provide details on current and previous clinical appointments (clinical names of organisations and dates of appointment)

Organisation	Term of Appointment
	to
	to
	to
	to
	to
	to
	to

b) Academic appointments and teaching experience

Organisation	Term of Appointment
	to
	to
	to
	to
	to

c) Quality Activities

d) Health status, if applicable (this may be discussed privately with the director of medical services or equivalent, who will then be responsible for deciding how this will affect the scope of clinical practice

e) Have you ever been denied a defined scope of clinical practice? **Yes/No**
Has your right to practice ever been withdrawn suspended or terminated? **Yes/No**

If you answered **YES** to either of the above questions, please provide details.

6. Continuing professional development (CPD) statements that are college approved or relevant to the scope of clinical practice determined by MAC and include either:

Evidence of compliance certificates

- Statements verifying CPD participation by the relevant college or Australian Medical Association CPD tracker printouts

7. Clinical review / Peer review

Do you regularly participate or agree to participate in formal quality and peer review activities?

Yes ☐ No ☐

Please provide details of quality/peer review activities.

6. Regulatory and indemnity information

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Medical Board of Victoria Registration (**Attach** a copy of current Registration Certificate)	Registration number
Confirmation of the type of registration: e.g. general or specialist	
Are you a recognised specialist under the relevant jurisdiction for the purposes of the payment for Medicare benefits to your patients?	
Please provide your Healthcare Provider Identifier – Individual (HPI-I)	
Current professional indemnity/medical indemnity cover, ensuring the cover reflects the requested scope of practice (**Attach** the original or a certified copy of current policy renewal certificate)	Expiry date of current policy
Confirmation of the presence or absence of conditions, undertakings, endorsements, notations and reprimands Is it subject to any restrictions? If restrictions apply, please provide details	
Have there ever been or are there any claims, court settlements or judgments against you > $200,000?	YES / NO
Has your medical defence organisation ever excluded any specific area of practice, or terminated or denied coverage?	YES / NO
If answer to any of the above is YES, Please discuss with Chairperson of Management Advisory Committee	
What is your Provider Number?	

7. Disclosure about disciplinary actions/criminal activity

i) Have you ever been the subject of prior disciplinary action or professional sanctions imposed by any Registration Board?

YES ☐ **NO** ☐

If yes, please attach separate pages, identified with the relevant section number.

ii) Have there been or are there any criminal charges pending against you or have you ever been convicted of any criminal charges?

YES ☐ **NO** ☐

If yes, please attach separate pages, identified with the relevant section number.

iii) Have you ever been convicted of a drug or alcohol related offence?

YES ☐ **NO** ☐

If yes, please attach separate pages, identified with the relevant section number.

8. Professional Referees

Please provide details of three independent professional referees, preferably at least two in your specialty, who have been in a position to judge your qualifications and experience during the past five years and who have no conflict of interest in providing a reference.

Referee 1

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
e-mail address	

Referee 2

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
e-mail address	

Referee 3

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
e-mail address	

9. Agreement/undertakings

I understand that in assessing my application for appointment as a visiting medical officer/dentist, Specialist Surgicentre will make additional enquiries as to my suitability for the position.

I authorise Specialist Surgicentre to obtain information relevant to my application from the Victorian Medical Practitioners Board or Australian Dental Association

YES ☐ **NO** ☐

I authorise Specialist Surgicentre to obtain information relevant to my application from my medical indemnity insurance organisation

YES ☐ **NO** ☐

I authorise the Specialist Surgicentre to seek information as to my past experience, performance and current fitness

YES ☐ **NO** ☐

I authorise access to the above information by representatives of Specialist Surgicentre's credentialing committee

YES ☐ **NO** ☐

If appointed, I agree to familiarise myself, and practice within the hospital by-laws, policies, procedures and code of conduct

YES ☐ **NO** ☐

If appointed, I agree to abide by confidentiality, open disclosure and privacy obligations and understand that breaches may result in the cessation of my appointment

YES ☐ **NO** ☐

I agree to notify the CEO or Board of Management Committee Chairman of any event/situation which may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters or otherwise

YES ☐ **NO** ☐

If appointed, I agree to comply with relevant ongoing educational/certification programs of my college/association/joint consultative committee and to furnish details to the health service on an annual basis as requested

YES ☐ **NO** ☐

If appointed, I agree to participate in annual peer review

YES ☐ **NO** ☐

If appointed, I agree to promptly notify the CEO and Medical Director of any adverse clinical incident I am involved in or become aware of

YES ☐ **NO** ☐

If appointed, 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** ☐

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Declaration

As recommended under the Standard for Credentialing and Defining the Scope of Clinical Practice of the Australian Council for Safety and Quality in Health Care with respect to the information required for initial credentialing of a medical practitioner, the health service requires that the following declaration is completed by applicant.

I hereby declare that I have not been subject to any prior change to the defined scope of clinical practice, or denial, suspension, termination or withdrawal of the right to practise (other than for organisational need and/or capability reasons) in any other organizations and that I have not been subject to any prior disciplinary action or professional sanctions imposed by any registration board.

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

Name of Applicant

Signature Date

If for any reason you are unable to sign the Declaration above, please explain the circumstances to the CEO or Medical Director

All applications for credentialing are considered by the facilities Board of Management Committee in line with current policies and protocols.

Office Use Only

Application presented to MAC: (date) Approval/Rejection: (date) Authorised by: (signature)

Documents from discussion for review for rejection: Rejection: (date) Notification of Rejection (date) Authorised by: (signature)