Geelong DAY SURGERY

APPLICATION FOR CREDENTIALING and PRACTICE RIGHTS

(CLINICAL PRIVILEGES)
Dental Practitioner

Name of dental practitioner

Surname

Given Names

AHPRA Registration number

Application for practice rights (Clinical privileges)

This is a: New application Renewal/reapplication Altered scope of practice

Please attach the following to this form:

1. Current curriculum vitae
2. Certified copies of all qualifications, including primary degree
3. Passport
4. Driver's Licence
5. National/International Police Check (less than 12 months)
6. Copy of current professional indemnity insurance certificate
7. Working with children check (if available)
8. COVID 19 immunisation (x2 + booster)
9. Flu immunisation history (Medicare)
10. Other Blood Tests:
    - Hepatitis B immunisation and antigen testing
    - TB immune status: Quantiferon Gold or proof of prior BCG immunisation
    - Measles, Mumps, Rubella and Varicella immune status or proof of vaccination
11. Continuing Professional Development Certificates (Points totalling to 25)
12. Copy of Radiation Licence from the Department of Health.

Professional Contact Details

Clinic/Practice Address:

Clinic Phone:

Clinic Email:

Personal Contact Details

Postal Address:

Personal Mobile:

Personal Email:

PBS Prescriber number:

Do you have a Medicare provider number for this location? Yes No
If NO, please note that you will be required to obtain one.

Provider number(s):

If YES, is it subject to any restrictions? Yes No
If restrictions apply, please provide full details.

Qualifications

Please list your qualifications below and provide certified copies of all qualifications obtained (initial application).

If application is for renewal of credentialing, please list and provide copies of, any new qualifications gained since initial credentialing.

If specific scope of practice is requested eg. Implant therapay, provide proof of relevant training.

Qualifications	University/Organisation	Year obtained
Primary dentistry degree		
Others		

Requested scope of clinical practice

Dental Implants *(If yes, attach certificate of training)*	Yes	No
Sinus augmentation under anaesthesia *(If yes, attach certificate of training)*	Yes	No
Endodontic treatment including post and core under anaesthesia	Yes	No
Periodontic treatment under anaesthesia	Yes	No
Tooth extraction under anaesthesia including wisdom teeth	Yes	No
Surgical exposure of unerupted teeth	Yes	No
Tooth fillings including fissure seals under anaesthesia	Yes	No
Crown/veneer inlays/inlays /bridges preparation under anaesthesia	Yes	No
Removal of calculus /cleans	Yes	No
Soft tissue surgeries gingivectomy /frenectomy	Yes	No
Dental fractures	Yes	No
Splinting of displaced teeth	Yes	No
Dentures	Yes	No
Biopsy of lesions/cysts	Yes	No

Other *(please specify)*

Prior History

Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a dental 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
Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?	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 Director of Medical Services only' appended to this application, and indicate here that additional information is provided separately in this manner.

Are you registered as a dental practitioner in any other country? course of your work *If yes, please specify*	Yes	No
Have you ever been registered as a dental practitioner in any other country? *If yes, please specify*	Yes	No

Professional indemnity insurance information

Name of insurer:

Policy number: Expiry date:

Please attach a copy of your current policy renewal certificate.

Is your proposed scope of private clinical practice reflected in or covered by your current professional indemnity insurance?	Yes	No
Have there ever been, or are there currently pending, professional indemnity claims, settlements or judgements against you?	Yes	No
Has your current or any previous professional indemnity 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 professional indemnity organisation/insurer.

Continuing professional development

	Yes	No
Is your proposed scope of private clinical practice reflected in or covered by your current professional indemnity insurance?		

Provide a copy of your Continuing Professional Development Certificates (Points totalling to 25)

Health status

	Yes	No
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 Director of Nursing 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.

Referee

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

Name

Current position

Phone (BH) Mobile

Email address

Name

Current position

Phone (BH) Mobile

Email address

Name

Current position

Phone (BH) Mobile

Email address

Agreement/undertakings

I understand that in assessing my application for appointment as a dental practitioner, Geelong Day Surgery will make additional enquiries as to my suitability for the position.

I understand Geelong Day Surgery will conduct a routine police check.	Yes	No
I authorise Geelong Day Surgery 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 Geelong Day Surgery, Policies and procedures and to abide by them.	Yes	No
I accept that Geelong Day Surgery will obtain information relevant to my application from the Dental Board of Australia and any other authority that regulates health practitioners.	Yes	No
I authorise Geelong Day Surgery to obtain information relevant to my application from my current and any previous professional indemnity organisation/insurer.	Yes	No
I authorise Geelong Day Surgery to obtain information relevant to my supervision requirements (where applicable).	Yes	No
I authorise Geelong Day Surgery 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 Geelong Day Surgery's 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 Director of Nursing/ Director of Medical Services of any event/ situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to professional registration matters, or otherwise. This includes matters about which I consider that the Director of Nursing/ Director of Medical Services 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 notify the Director of Nursing/Director of Medical Services of any action taken by another healthcare organisation to suspend, terminate or vary my rights of practice or scope of clinical practice. I undertake to do this within 10 working days of such action being taken.	Yes	No
I agree to practice in accordance with the Australian Health Professions Registration Authority Share Code of Conduct and that of my College	Yes	No

I agree to practice in accordance with relevant Clinical Care Standards, as defined by the Australian Commission for Safety and Quality in Healthcare and relevant guidelines published by my College and Safer Care Victoria.	Yes	No
I agree to participate in Geelong Day Surgery's performance development and support process (Partnering for performance or equivalent).	Yes	No
I agree to promptly notify the Director of Nursing/ Director of Medical Services 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 Geelong Day Surgery may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	Yes	No

Declaration

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

Date

Please note: the information collected on this form will be used by the Geelong Day Surgery Medical Advisory and Credentialing Committee (MACC) to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

Geelong Day Surgery operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of privacy and confidentiality policies are available upon request.