Geelong DAY SURGERY

APPLICATION FOR CREDENTIALING and PRACTICE RIGHTS

(CLINICAL PRIVILEGES)
Medical Practitioner

Name of medical practitioner

Surname

Given Names

Medical Registration number

Application for practice rights (Clinical privileges)

I wish to undertake a scope of practice for:

Anaesthetist

Physician with specialty gastroenterology and hepatology

Surgeon (Please list specialty area): _____

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 specialist or other qualifications, other than a primary medical degree, if these are not listed on the Medical Board of Australia website at

   http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx
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
    - If anaesthetist, provide ANZCA Certificate of Compliance.
    - If gastroenterologist, provide GESA Certificate.
    - If surgeon, provide CPD Certificate from the Royal College of Surgeons or relevant college.

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. Endoscopy, provide proof of relevant training, eg. Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy

Qualifications	University/Organisation	Year obtained
Primary medical degree		
Others		

Requested scope of clinical practice

Anaesthesia	• General anaesthesia, including the use of muscle relaxants	Yes	No
	• General anaesthesia with spontaneous ventilation	Yes	No
	• Spinal and Epidural Anaesthesia	Yes	No
	• Regional local anaesthetic blocks, including intravenous regional blocks	Yes	No
	• Local anaesthesia by infiltration	Yes	No
	• Intravenous sedation	Yes	No
Gastrointestinal Endoscopy	• Gastroscopy: diagnostic		
	° Oesophageal & pyloric dilatation	Yes	No
	• Colonoscopy & fibreoptic sigmoidoscopy: diagnostic		
	° Polypectomy using cold snaring	Yes	No
	° Polypectomy using hot snaring	Yes	No
	° Application of endoscopic clips	Yes	No
	° Haemorrhoid banding	Yes	No
General Surgery	• Excision of skin lesions	Yes	No
	• Excision or subcutaneous lesions eg Lipoma	Yes	No
	• Excision of anal tags	Yes	No
	• Anorectal examination under anaesthesia		
	° Injection and banding of haemorrhoids	Yes	No
	° Botox injection for anal fissure	Yes	No
	° Lateral sphincterotomy	Yes	No
	° Excision of anal tags	Yes	No
	• Umbilical hernia repair	Yes	No
	• Open repair of inguinal or femoral hernia	Yes	No
	• Excision of scrotal lesions including epididymal cysts and open correction of hydrocoele & varicocoele	Yes	No
	• Circumcision	Yes	No
	• Vasectomy	Yes	No
	• Carpal tunnel decompression	Yes	No
	• Trigger finger release	Yes	No
	• Dupuytren's contracture	Yes	No
	• Tendon repair	Yes	No
	• Nerve repair	Yes	No
	• Others: _____	Yes	No

Requested scope of clinical practice

Interventional Radiology	• Ligation, stripping, avulsion, injection of varicose veins (one leg at a time)	Yes	No
Ophthalmology	• Cataract surgery	Yes	No
Oral and Maxillo Facial Surgery	• Excision of skin cancer lesions – full excision including reconstructive	Yes	No
	• Hand surgery	Yes	No
	• Simple Facial Reconstruction	Yes	No
	• Cosmetic Surgery	Yes	No
	• Others: _____	Yes	No
Plastic Surgery	• All surgical procedures involving the teeth and oral cavity	Yes	No
	• Dental implants	Yes	No
	• Sinus surgery including augmentation and bone grafting	Yes	No
	• Biopsy of lesions/cysts	Yes	No
	• Surgery of jaw, temporomandibular joints and salivary gland appropriate for day stay	Yes	No
	• Others: _____	Yes	No
Urology	• Circumcision	Yes	No
	• Vasectomy	Yes	No
	• Vasectomy reversal	Yes	No
	• Cystoscopy	Yes	No
	• Ureteroscopy	Yes	No
	• Others: _____	Yes	No

Prior History

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
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 medical practitioner in any other country? *If yes, please specify.*	Yes	No
Have you ever been registered as a medical practitioner in any other country? If yes, please specify.	Yes	No

Medical 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 medical indemnity insurance?	Yes	No
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.

Continuing professional development

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

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

Quality activities

Have you participated in regular clinical reviews, audits and/or peer-review activities in any clinical setting?	Yes	No

If YES, please provide details of these activities (provide attachments if necessary).

Health status

Do you have a disability or health issue that:	Yes	No
• 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 medical 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 Medical 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 medical 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 medical 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 medical 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 Medical Board of Australia Code of Conduct for Medical Practitioners and that of my College.	Yes	No

I agree to practice in accordance with the Medical Board of Australia Code of Conduct for Medical Practitioners and that of my College.	Yes	No
I agree to practice in accordance with the Medical Board of Australia Code of Conduct for Medical Practitioners and that of my College.	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.