GENERIC CREDENTIALING AND SCOPE OF PRACTICE APPLICATION FORM (QLD)

Developed by members of the Private Hospitals Association of Queensland Inc. – V4- Amended April 2010

Private and Confidential

APPLICATION FOR APPOINTMENT AND SCOPE OF CLINICAL PRACTICE AS AN ACCREDITED PRACTITIONER

PLEASE PRINT OR TYPE, TICK RELEVANT BOXES, AND SIGN THE FORM.

PLEASE RETURN THE FORM TO:

Executive Assistant - gilliesc@sath.org.au
Executive Office St Andrew's Toowoomba Hospital PO Box 263 Toowoomba Qld 4350
Telephone: 07 4646 3101

ALL NEW APPLICATIONS MUST BE ACCOMPANIED BY TWO WRITTEN REFERENCES, CURRICULUM VITAE, PROOF OF REGISTRATION AND PROFESSIONAL INDEMNITY

NEW APPLICATION ❑ RENEWAL APPLICATION ❑ (Application Form Only)

PERSONAL AND CONTACT INFORMATION			
Surname		Given Names	
Preferred Title (e.g. Dr, Mr, A/Prof; Prof)		Preferred Name	
Any former names, including maiden name		Date of Birth	
Home Address ✉ preferred mailing address ❑	PCode	Phone (home)	
		Mobile Phone	
		Pager	
		Facsimile	
Email (personal)		Email (business)	

Emergency Contact Person		Relationship	
Phone (work)		Phone (home)	
Phone (mobile)		Preferred telephone contact order ie home, mobile	

Provider Number		Prescriber Number	

Name of Partner/ Spouse (for Hospital invitation list)	

PROFESSIONAL PRACTICE DETAILS			
Practice Name (1)			
Business Address (Primary Consulting Room) ✉ preferred mailing address ❑	PCode	Phone	
		Facsimile	

Practice Name (2)			
Business Address (Other Consulting Rooms) ✉ preferred mailing address ❑	PCode	Phone	
		Facsimile	

PROFESSIONAL REGISTRATION DETAILS (Please attach copy of your Registration certificate)

Registration Number		Expiry Date	
Category of Registration			

Are there any conditions or undertakings currently attached to this registration? Yes ❑ No ❑
If yes, please give details.

Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board, dental board or other registration board (as appropriate)? Yes ❑ No ❑
If yes, please give details of the restriction and what period during which the restrictions apply/applied.

PROFESSIONAL INDEMNITY (Please attach copy of your professional indemnity certificate)

Indemnity Insurance Number		Category of Coverage	
Insurance Company			

Does your membership fully cover the scope of clinical practice you have applied for? Yes ❑ No ❑

Has your medical defence insurer or any medical defence insurer or fund of which you have been a member ever applied conditions or refused to renew your cover or membership (in part or in full)? Yes ❑ No ❑
If yes, please provide details.

Are there any current claims for compensation against you or complaints lodged with the Australian Health Practitioners Regulation Agency (AHPRA) or Health Ombudsman?
Yes ❑ No ❑
If yes, please provide details.

Have there ever been any adverse findings made against you which would be relevant to your appointment (for example: breach of insurance/medical laws, professional misconduct, sexual assaults or assault) by the Health Insurance Commission, a Medical or Registration Board, Health Ombudsman, a Coroner, a Court or any other negligence, professional, disciplinary or similar body?
Yes ❑ No ❑

Criminal Record Check – Have you been convicted of, or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)?
Yes ❑ No ❑

If yes, and if not prevented by confidentiality agreements, could you please provide a brief description of each adverse judgement or settlement, and the year in the event occurred?

* This information is required to assess an application for scope of clinical practice and will only be used by St Andrew's Toowoomba Hospital for such purposes. Information provided will not be disclosed otherwise.

Please nominate a Medical Practitioner accredited at the Hospital in your Specialty available for contact by the Hospital in the case of an emergency if you are unavailable, and who has agreed to deputise for you.

Name	
Specialty	
Contact Number	

CLINICAL PRACTICE SOUGHT IN THE FOLLOWING CATEGORY(S) (Please tick)

- ❑ Specialist Medical Practitioner
- ❑ General Medical Practitioner
- ❑ Registrar or Advanced Trainee
- ❑ Locum Tenens
- ❑ Dental Practitioner
- ❑ Surgical Assist (no admit rights)
- ❑ Allied Health Professional
- ❑ Employed Medical Officer
- ❑ Nurse Practitioner
- ❑ Registered Nurse (employed by VMO)
- ❑ Registered Nurse working in specialised area

PRIVILEGES SOUGHT (Please tick)

- ❑ Admitting
- ❑ Consulting
- ❑ Surgical Assist
- ❑ Anaesthetic
- ❑ Surgical
- ❑ Surgical (RN Only)
- ❑ Procedural
- ❑ Allied Health
- ❑ Nursing Assessment & Patient Education
- ❑ Contract of Employment (Employed Medical Officers)
- ❑ Contract of Employment (Employed Allied Health Professional)

DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED: (Not applicable to Surgical Assistants) (Please tick)

- ❑ Anaesthesia
  - ❑ Adults
  - ❑ Cardiac
  - ❑ Neonatal
  - ❑ Obstetric
  - ❑ Paediatric
  - ❑ Other ________________
- ❑ Cardiac Surgery
  - ❑ Adult
  - ❑ Paediatric
- ❑ Dental
  - ❑ Paediatric
  - ❑ Oral & Maxillofacial
- ❑ Dermatology
  - ❑ Adult
  - ❑ Paediatric
- ❑ Emergency Medicine
  - ❑ Adult
  - ❑ Paediatric
- ❑ Endocrinology
  - ❑ Adults
  - ❑ Paediatric
- ❑ ENT Surgery
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Paediatric Endoscopic
  - ❑ Head and Neck
- ❑ Gastroenterology
  - ❑ Endoscopy
  - ❑ ERCP
  - ❑ Other ________________
- ❑ General Surgery
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Endoscopy
  - ❑ Laparoscopic Surgery
  - ❑ Other ________________
- ❑ Intensive Care
  - ❑ Adult
  - ❑ Paediatric
- ❑ Neonatology
  - ❑ Category 1
  - ❑ Category 2
  - ❑ Category 3
  - ❑ Category 4
- ❑ Neurosurgery
  - ❑ Adult
  - ❑ Paediatric
- ❑ Nuclear Medicine
- ❑ Obstetrics & Gynaecology
  - ❑ Gynaecology General
  - ❑ Obstetrics
  - ❑ Gynaecological Oncology
  - ❑ Uro-gynaecology
  - ❑ Ultrasound
  - ❑ Advanced Endoscopic Surgery
  - ❑ Laparoscopic Surgery
  - ❑ Maternal Fetal Medicine
  - ❑ Other ________________
- ❑ Occupational Medicine
- ❑ Ophthalmology
  - ❑ Adult
  - ❑ Paediatric
- ❑ Oral & Maxillofacial Services
  - ❑ Facio Maxillary Surgery
- ❑ Orthopaedics
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Other ________________
- ❑ Paediatric Medicine
  - ❑ General Medicine
  - ❑ Oncology/Haematology
  - ❑ Neurology
  - ❑ Nephrology
  - ❑ Respiratory
  - ❑ Rheumatology
  - ❑ Cardiology
  - ❑ Other ____________________
- ❑ Paediatric Surgery
  - ❑ Neonatal
- ❑ Palliative Care
- ❑ Pathology
  - ❑ Anatomical
  - ❑ Biochemistry
  - ❑ Laboratory Haematology
  - ❑ Infectious Diseases
  - ❑ Microbiology
- ❑ Perfusion
- ❑ Physicians/Internal Medicine
  - ❑ Clinical Haematology
  - ❑ General Medicine
  - ❑ Geriatrics
  - ❑ Medical Oncology
  - ❑ Neurology
  - ❑ Nephrology
  - ❑ Respiratory
  - ❑ Rheumatology
  - ❑ Other ________________
- ❑ Plastic & Reconstructive Surgery
  - ❑ Adults
  - ❑ Paediatric
- ❑ Psychiatry
  - ❑ Sub Specialty specify: ____________________
  - ❑ ECT
  - ❑ CYMH
- ❑ Medical Imaging
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Radiation Oncology
  - ❑ Other ________________
- ❑ Rehabilitation Medicine
- ❑ Urology
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Other ________________
- ❑ Vascular Surgery
- ❑ Thoracic Surgery
  - ❑ Adult
  - ❑ Paediatric

OTHER CLINICAL PRACTICE SOUGHT (Not applicable to Surgical Assistants)

FIELD	Surgical Admitting	Medical Admitting	Consulting	Other (Specify)
	❑	❑	❑	❑

CLINICAL PRACTICE SOUGHT AS THE FOLLOWING SPECIALIST(S) IN THE CARDIOVASCULAR UNIT (Please tick)

- ❑ Cardiologist
- ❑ Interventional Cardiologist
- ❑ Electrophysiologist
- ❑ Interventional Radiologist
- ❑ Vascular Surgeon

DETAIL THE AREAS OF CLINICAL PRACTICE REQUESTED: (Please tick)

- ❑ Cardiology
  - ❑ Diagnostic Procedures
  - ❑ Interventional Procedures
  - ❑ EP Procedures
  - ❑ Implantable Electronic Devices
  - ❑ Paediatric Procedures
- ❑ Endovascular Procedures
  - ❑ Diagnostic Procedures
  - ❑ Peripheral Interventions
  - ❑ Carotid Interventions
  - ❑ AAA Stent Grafts
  - ❑ Embolization Procedures

COMPETENCY GUIDELINES: (Please tick)

Cardiology	During Training or within the last 5 years of clinical practice (did you meet or exceed these amounts – if not what quantity?)	Current Practice - across all institutions you visit (do you meet or exceed these amounts – if not what quantity?)
Diagnostic Procedures	❑ participate in 400 Coronary Angiograms ❑ perform 150 cases as supervised operator ❑ perform 150 cases as primary operator	❑ 100 cases / year
Interventional Procedures	❑ participate in 400 cases (100 complex) ❑ perform 200 cases as primary operator	❑ 75 cases / year
Electrophysiology Studies	❑ participate in 150 diagnostic cases ❑ participate in 100 ablation cases ❑ perform 50 cases as primary operator ❑ perform 10 trans-septal catheterizations	❑ 40 cases / year (30 as ablations)
Implantable Electronic Devices (pacemakers and ICD's – single, dual & Bi-V, active & passive fixation)	❑ perform 75 implants ❑ perform 20 revisions ❑ perform 15 Bi-Ventricular implants	❑ 12 pm & 10 ICD implants / year ❑ 5 revisions / year ❑ follow 50 PM & 20 ICD patients / year
Cardiac Interventions (valvuloplasty, PFO/ASD Closures etc)		❑ 5 cases / year
Endovascular		
Peripheral Angiography	❑ perform 100 cases (50 as primary operator)	❑ 20 cases / year
Peripheral Interventions	❑ perform 50 cases (25 as primary operator)	❑ 20 cases / year
Carotid Interventions	❑ perform 100 peripheral angiograms (not only carotids) ❑ perform 15 cases (10 as primary operator)	❑ 10 cases / year
AAA Stent grafts	❑ perform 10 cases (5 as primary operator)	❑ 5 cases / year
Cerebral Embolizations	❑ perform 100 cervicocerebral angiograms ❑ perform 20 cerebral embolizations	❑ 5 cases / year
Ovarian Vein Embolizations	❑ perform 50 cases (25 as primary operator)	❑ 10 cases / year

CVU AUDIT GUIDELINES: (Please tick)

- ❑ I will participate in regular case / image review audits
- ❑ I will participate in regular mortality / morbidity data audits
- ❑ I will participate in regular procedural outcome and complication data audits
- ❑ I will participate in regular radiation safety audit and review

REFEREES	NEW APPLICATIONS MUST BE ACCOMPANIED BY TWO WRITTEN REFERENCES BEFORE THEY WILL BE CONSIDERED

For each major specialty in which you are seeking clinical practice, please provide names, addresses, telephone numbers, facsimile numbers and email addresses of three (3) professional referees (at least one from your own profession) who can attest to your recent practice and have known you for at least 12 months within the past 3 years. We prefer (where possible) that these referees are independent. However, where there is a relationship which may lead to a bias, such as a referee and the applicant are in business together as a partnership, or are employer/employee, then this relationship must be disclosed by you to the hospital. New applications must be accompanied by two written references before they will be considered.

Specialty			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

Specialty			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

PRIMARY UNDERGRADUATE QUALIFICATION (List below or attach CV)

Name of University/ Institution	Degree/s	Graduation Year

POSTGRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS, COLLEGE OR PROFESSIONAL QUALIFICATIONS (List below or attach CV – copies of qualification/s to also be attached)

Qualification	Date Obtained	Accredited Training Organisation

PROFESSIONAL DEVELOPMENT OVER PAST 3 YEARS - Please include any research activities, funded projects and quality assurance activity.(List below or attach CV)

CURRENT PUBLIC HOSPITAL APPOINTMENTS (List below or attach CV)	
Hospital	**Appointment**

CURRENT SCOPE OF CLINICAL PRACTICE AT OTHER PRIVATE HOSPITALS (List below or attach CV)	
Hospital	**Appointment**

Have you previously been refused clinical privileges at another health care facility?

Yes ❑ No ❑

If yes, please provide the name of the facility and rationale for refusal. *Please note a senior executive of the Hospital may contact the facility.*

Has your scope of clinical practice and/or appointment at any Hospital or Day Procedure Centre ever been reduced, suspended or revoked (including if done by mutual agreement) or have you had conditions attached to that appointment for any reason?

Yes ❑ No ❑

If yes, please give dates and particulars. *Please note a senior executive of the Hospital may contact the facility*

DETAILS OF ALL HEALTH CARE RELATED EMPLOYMENT WITHIN THE LAST 10 YEARS (List below or attach CV)	
Hospital	**Appointment**

SPECIAL PROFESSIONAL INTERESTS

PROFESSIONAL AFFILIATIONS

Are you a member of any Specialist College(s)/Association(s)? (If yes, please provide details) Yes ❑ No ❑

PUBLICATIONS (List below or attach CV)

NOTE: COPIES OF THE FOLLOWING MUST ACCOMPANY **ALL NEW** APPLICATIONS:

- ❑ CURRICULUM VITAE
- ❑ EVIDENCE OF QUALIFICATIONS AND PARTICIPATION IN CONTINUING MEDICAL EDUCATION
- ❑ PROOF OF REGISTRATION
- ❑ PROFESSIONAL INDEMINITY – CERTIFICATE OF CURRENCY

DECLARATION AND AUTHORITY

I authorise the ST ANDREW'S TOOWOOMBA HOSPITAL, its employees, officers and the Medical Advisory Committee, to obtain information on an annual, or as necessary, basis from the registration body/indemnity insurance organisation as nominated in this application, regarding the currency of my registration/membership of that body/organisation.

Specialist Directory
I authorise the ST ANDREW'S TOOWOOMBA HOSPITAL to include my practice details in any Hospital Specialist Directory. Yes ❑ No ❑

I authorise ST ANDREW'S TOOWOOMBA HOSPITAL to conduct a criminal record check in respect of my history including information relevant to the provision of services to children and I agree to notify the Chief Executive Officer if I am convicted of a sex or violence offence or any other offence relevant to my practice as a Medical Practitioner.

I authorise the ST ANDREW'S TOOWOOMBA HOSPITAL, its officers and the Medical Advisory Committee to verify with relevant individuals, external organisations, and nominated referees the validity of all claims, including complaints made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history, claims and legal proceedings.

I declare that I have no physical or mental condition or substance abuse problem that could affect my ability to exercise the scope of clinical practice requested or that would require any special assistance in order to enable me to exercise that scope of clinical practice safely and competently. I undertake to notify the ST ANDREW'S TOOWOOMBA HOSPITAL if this statement becomes incorrect in the future.

I declare that my medical indemnity/professional indemnity cover is adequate and appropriate for the Clinical Privileges and activity which is the subject of this application.

I declare that I am the person named in this application and that the information provided by me in this application and in connection with this 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 the St Andrew's Toowoomba Hospital Board may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.

In applying for appointment I acknowledge that I have been provided with, and read, a copy of the Hospital By-Laws and if appointed, agree to abide by the By-Laws and policies of the ST ANDREW'S TOOWOOMBA HOSPITAL, including any annexure or variation to the By-Laws during the tenure of my appointment, all relevant legislative requirements (including compliance with Australian Commission Safety and Quality Healthcare (ACSQHC) Standards) and any terms and conditions which are attached to my appointment by the Board/Licensee. I understand that non-compliance with the Hospital By-Laws may be grounds for suspension, termination or imposition of conditions on my clinical privileges.

I undertake to notify the ST ANDREW'S TOOWOOMBA HOSPITAL promptly and in writing, if my scope of clinical practice is altered in any way at any other hospital or day procedure centre.

I agree to attend committee and clinical meetings at the facility to support my discipline within the facility, and to participate in any clinical quality assurance activity including submitting my practice to clinical audit and peer review, in conjunction with the hospital, the Medical Advisory Committee or clinical specialty committees if required by ST ANDREW'S TOOWOOMBA HOSPITAL.

I undertake to notify ST ANDREW'S TOOWOOMBA HOSPITAL should any information provided in this application for appointment vary in any way

In the event of myself or the aforementioned practitioner(s) being unavailable in the case of an emergency, I am agreeable to the facility seeking urgent alternative assistance with authority to be exercised only after consultation with the facility Chief Executive Officer or duly authorised person.

I understand that my Appointment will be reviewed in one (1) year for Appointments and five (5) years for Re-Appointments or earlier if considered necessary.

SIGNATURE ___________________________________ DATE _____/_____/_____

WITNESS NAME ______________________________ WITNESS SIGNATURE _____________________ DATE _____/_____/______

CONSIDERATION OF ACCREDITED PRACTITIONER APPLICATION FOR APPOINTMENT FORM

OFFICE USE ONLY

Application Form Completed & CV Received Y ❑ N ❑		**PRIVILEGES GRANTED** Approved by Licensee as evidenced by the letter sent on behalf of the Licensee, confirming the appointment, including the Fire & Emergency Management Policy HP018 Y ❑ N ❑
Copy of Registration Received Y ❑ N ❑		Website Specialist List updated if applicable Y ❑ N ❑
Copy of certificate of currency for Medical Indemnity Insurance received. Y ❑ N ❑		VMO added to ePAS Y ❑ N ❑
Recommended by Medical Advisory Committee	Date: Signature:	VMO added to email distribution list Y ❑ N ❑
Recommended by Chief Executive Officer/Medical Director	Date: Signature:	
Relevant References Received Y ❑ N ❑ References Reviewed for Specialists Y ❑ N ❑		