Application for appointment, Credentialing and Scope of practice for the Senior Medical and Dental Staff

CHECKLIST	CANDIDATE TO FILL	FOR OFFICE USE ONLY
Applicants Name		
	Checked ❑ (✓)	Checked ❑ (✓)
1. Contact details provided	❑	❑
2. Credentials: - attach CERTIFIED copies (in order)	❑	❑
(i) MBBS (or equivalent certificate)	❑	❑
(ii) Fellowship (or equivalent certificate)	❑	❑
(iii) AHPRA registration details (if applicable)	❑	❑
(iv) Medical Indemnity certificate	❑	❑
(v) Any other additional certificates	❑	❑
(vi) Copies of relevant Visa documents (if applicable)	❑	❑
(vii) CV	❑	❑
3. Training and experience		
4. Clinical appointments		
5. Continuing medical education/continuing professional development		
6. Provider number		
7. Referees		
8. Existing contract/employment arrangements checked and relevant documentation available		
9. Declaration signed		
10. Other comments:		

_____

_____

Application details check by (name)

Signature _____ Date _____

Decision of MACC (Medical Appointments and Credentialing Committee) at its meeting on

Application Approved ❑ Rejected ❑

If application rejected, detail reasons

_____

_____

Letter to applicant advising of application outcome Yes ❑ Copy attached ❑

Scope of practice created and signed by applicant Yes ❑ Copy attached ❑

Applicant to fill (Type):

Please note: If you need to correct any error in your application, please initial the correction.

POSITION APPLIED FOR/ PRIMARY SPECIALTY	
Sub-specialty or area of special interest (if applicable)	
SECONDARY SPECIALITY (if applicable)	

1. Applicant and contact details

Surname	
Given Name/s	
Previous Name Please include your previous name if that appears on certificates	
Date of Birth	
Place of Birth	
Residency status (Australian citizen/permanent/temporary resident)	
Professional Address	
Phone (BH)	
Phone (AH)	
Fax	
Mobile	
Pager	
e-mail address	
Postal Address (if different to Professional Address above)	
Private Address	

2. Application for scope of clinical practice*

I wish to apply to define my scope of clinical practice to undertake the following:

Position/classification sought
Scope of clinical practice sought (Please use additional pages if required) • • •

Please attach a copy of your full CV to this application

Qualifications (undergraduate/postgraduate/formal recognised training for specialist qualifications)

Qualification	University/organisation	Year obtained

Please provide copies of qualifications obtained

4. Other training and clinical experience

With respect to your response to **Question 2**, please provide details of relevant clinical experience and post-qualification training.

Include the title of course/s undertaken, the organisation offering the course, and the qualification obtained.

5. Clinical appointments

(a) Provide details on all current and previous clinical appointments (including names of organisations and dates of appointment) or other places of practice (for example, general practice).

Organisation	Term of appointment
Major appointment:	to
Other appointments:	to
	to
	to
	to
	to
	to
	to
	to

(b) Have you ever been denied a defined scope of clinical practice?	Yes☐ No☐

(c) Has your right to practise ever been withdrawn, suspended, terminated or reduced?	Yes☐ No☐

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

6. Academic appointments/teaching experience

Provide details on current and previous teaching appointments (including names of organisations and dates of appointment).

Organisation	Status/level	Term of appointment
		to
		to
		to
		to
		to
		to
		to

7. Continuing medical education/continuing professional development

(a) Provide details of your involvement in current continuing medical education/continuing professional development. Include name of the college/organisation program in which you are enrolled and maintenance of activity log book.

(b) Have you satisfied the continuing medical education/continuing professional development requirements for your college membership/fellowship?	Yes☐ No☐

8. Clinical review/peer review

Do you regularly participate in formal quality and peer review activities?	Yes☐ No☐

Provide details on such quality/peer review activities.

9. Grand rounds/health service educational activities

Are you prepared to conduct a grand round or other educational activities, for example, on a once a year basis?	Yes☐ No☐

10. Have you any other information to support this application?

11. Health status

Do you have a disability/health issue that: may impact on your ability to perform any of the cognitive and physical functions which 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?, or might be relevant to determining your scope of practice? (In answering this question, please have regard to publications of the Medical Practitioner's Board of Australia available at www.medicalboard.gov.au; under 'doctor's health', such as the *Blood borne infectious diseases policy*, which limits who may perform 'exposure prone procedures').	Yes☐ No☐

If yes, please provide details of the disability/health issue, its impact on your ability to carry out the scope of practice sought, and details of any special equipment facilities or work practices required.

This information can be provided on this form or, if you prefer, you can provide the information in a sealed envelope marked 'confidential for medical director only' appended to this application, and indicate here that additional information is provided separately in this manner.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent/reasonable requirements of the work which you seeking to perform at the hospital by submitting this application, or whether any reasonable adjustments might be required to ensure that you can work at the hospital in a way that ensures patient safety.

12. Regulatory and indemnity information

Medical Board of Australia Registration Is this registration temporary? If yes, provide details. (Attach a copy of current registration certificate)	Registration number Yes☐ No☐
If you have registration pertaining to an area of need, please detail the type of assessment process undertaken prior to registration	
Are you registered as a medical practitioner in any other state or territory of Australia, or in another country? If so, please specify.	Yes☐ No☐
If you have a specific registration and/or are required to undertake supervision please provide details including name and location of supervisor and frequency of supervision	
Do you have any conditions or restrictions placed on your registration (either in Victoria or elsewhere)? If so, please provide full details	Yes☐ No☐
In the past have you ever had any conditions or restrictions placed on your registration (either in Victoria or elsewhere)? If so, please provide full details	Yes☐ No☐
Current medical indemnity cover (if applicable) - attach a copy of current policy renewal certificate	Expiry date of current policy
Is your proposed scope of clinical practice reflected in or covered by your current medical indemnity insurance?	Yes☐ No☐
Have there ever been or are there currently pending any claims, settlements or judgments 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 any of the above is YES, please provide a detailed explanation (and specify the name of the relevant medical defence organisation/insurer).	
Do you have a Provider number for the Royal Children's Hospital? If YES, is it subject to any restrictions? If YES please provide details If restrictions apply, please provide full details.	Yes☐ No☐ Yes☐ No☐ _____
Do you have a Prescriber Number? If YES please provide details.	Yes☐ No☐ _____
Are you a recognised specialist under the relevant jurisdiction for the purposes of the payment of Medicare benefits to your patients?	Yes☐ No☐

13. Disclosure about disciplinary actions/criminal activity

Have you ever been the subject of disciplinary action in the course of your work as a medical practitioner?	Yes☐ No☐
If YES, please describe.	
Have you ever been the subject of prior disciplinary action or professional sanctions imposed by any registration board (whether in Victoria or elsewhere)?	Yes☐ No☐
If YES, please describe.	
Have you ever been the subject of any investigation, inquiry or findings by any registration board (whether in Victoria or elsewhere) in relation to your ability to practise or have direct patient contact, or regarding your professional performance or your professional conduct?	Yes☐ No☐
Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence? Are you the subject of pending criminal charges?	Yes☐ No☐ Yes☐ No☐
If YES to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'confidential for medical director only' appended to this application, and indicate here that additional information is provided separately in this manner.	
Have you ever had any adverse findings made against you that may be relevant to your appointment (in addition to anything you may have noted above)?	Yes☐ No☐
If YES, please provide full details.	

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

14. 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	
Phone (BH)	
Phone (Mobile)	
Fax	
e-mail address	

Referee 2

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

Referee 3

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

15. Agreement/undertakings

I understand that in assessing my application for appointment as a visiting medical practitioner, the health service will make additional enquiries as to my suitability for the position.

I authorise the health service to conduct a criminal history check in relation to my history.	Yes☐ No☐
I authorise the health service to obtain information relevant to my application from the Medical Practitioners Board of Australia and any other board regulating health practitioners, whether in Victoria or elsewhere.	Yes☐ No☐
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	Yes☐ No☐
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes☐ No☐
I authorise the health service to seek information as to my past experience, performance and current fitness from my referees and from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes☐ No☐
I authorise access to the above information by representatives of the health service's credentialing committees.	Yes☐ No☐
If appointed, I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them.	Yes☐ No☐
If appointed, I agree to abide by confidentiality and privacy obligations and understand that breaches may result in the cessation of my appointment.	Yes☐ No☐
I agree to notify the Director of Medical Services/medical leader 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. This includes matters about which I consider that the Director of Medical Services/medical leader 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, reductions in registration or insurance).	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 by the Director of Medical Services/medical leader.	Yes☐ No☐
If appointed, I agree to participate in annual performance appraisal.	Yes☐ No☐
I agree to promptly notify the Director of Medical Services/medical leader 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☐
If appointed, should any question as to my credentialing or clinical practice arise, I agree that the health service may make such inquiries as it considers necessary to assess whether that credentialing or my scope of clinical is appropriate.	Yes☐ No☐

Declaration

As recommended under the Standard for Credentialing and Defining the Scope of Clinical Practice of the Australian Commission 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 applicants.

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 organisations 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.

Signature of Applicant .....Date .....

Please note: If for any reason you are unable to sign the Declaration above, please explain the circumstances.

Certified Copies of required documentation MUST be provided to the following address:

HR Advisor, Senior Medical Workforce
The Royal Children's Hospital, Melbourne
50 Flemington Road,
Parkville Vic 3052