ACCREDITATION FORM

25 Queenslea Drive Claremont WA 6010
P O Box 45 Claremont WA 6910
Phone: (08) 9340 6300
Facsimile: (08) 9340 6399
www.bethesda.asn.au

TERM OF ACCREDITATION/CLINICAL PRIVELEGES:	
❑ SURGICAL ASSISTANT	❑ 1 year
❑ OTHER HEALTH PRACTITIONERS ______________________	❑ 3 years (standard accreditation term)

PERSONAL DETAILS:	
Title: ☐ Dr ☐ Mr ☐ A/Prof ☐ Prof ☐ Mrs ☐ Ms Other	
Surname:	First Name:
Date of Birth:	Preferred Name:
Home Address:	
	Postcode:
Home Telephone No.	

PROFESSIONAL DETAILS:			
Medicare Provider Number:			
Professional Board Registration No.:			
Professional Indemnity Insurer:			
Professional Indemnity Membership Number:			
Professional Indemnity Insurance – Field of Practice:			
Name of Clinic/Practice:			
Practice Manager:			
Street Address:			
	Postcode:		
Postal Address			
	Postcode:		
Telephone:	Facsimile:		
Mobile:	Pager:		
E-mail:			
Preference for correspondence:	❑ Home	❑ Work	❑ Postal

PROFESSIONAL QUALIFICATIONS			
Primary Degree:			
Postgraduate Degree(s):			
Postgraduate Diploma/Fellowship:			

PRACTICE HISTORY		
Have you been subject to denial, suspension, termination or withdrawal of the right to practice in any other organisation If yes, please provide full details (attach separate page if necessary)	❑ Yes	❑ No
Have you been the subject of disciplinary action or professional sanctions by any registration board, HIC, regulatory authority or similar body? If yes, please provide full details (attach separate page if necessary)	❑ Yes	❑ No
Have you been the subject of any criminal investigation or conviction? If yes, please provide full details (attach separate page if necessary)	❑ Yes	❑ No
Have you any physical or mental condition or substance abuse that could affect your ability to exercise the scope of practice request or that would require any special assistance in order to enable you to exercise that scope of practice safely and competently? If yes, please provide full details (attach separate page if necessary)	❑ Yes	❑ No

PLEASE PROVIDE TWO REFEREES WHO WILL PROVIDE A VERBAL AND/OR WRITTEN REFERENCE TO HOSPITAL			
Name:		Name:	
e-mail:		e-mail:	
Phone No.:		Phone No.:	

AGREEMENT	
As a practitioner you have access to information relating to the company's business, the patients, employees and agents of the hospital. The hospital seeks to preserve the secrecy of this confidential information and the duty of the hospital to meet WA and Commonwealth statutory obligations in protecting the privacy of patient information. i) A practitioner shall maintain the secrecy of the confidential information and shall prevent its unauthorised disclosure to or use by any other person, firm or company; ii) A practitioner shall not use the confidential information for any purpose other than for the benefit of the patient or hospital *during* or *after* his or her appointment by the hospital; iii) A practitioner shall not remove confidential business, patient, employee or agents information from the premises of the hospital without the consent of the hospital in accordance with written procedure and legislation; iv) A practitioner shall return any or all confidential information to the hospital immediately upon being requested so to do; v) A practitioner will adhere to hospital policies in the handling of patient information. I understand and agree to abide by these confidentiality principles.	❑ Yes
I undertake to notify the Hospital if my clinical privileges are changed at any other hospital or day procedure centre.	❑ Yes
I authorise the Hospital, its officers and the Credentials Committee to seek information as to past experience, performance and current fitness.	❑ Yes
I agree to provide to the Hospital up to date evidence of current indemnity insurance and AHPRA registration.	❑ Yes
I agree to participate in the Hospital's clinical activities.	❑ Yes
I agree to confine my practice within the Hospital to the clinical area/s applied for.	❑ Yes
I declare that the statements contained in this application are correct. In applying for appointment I agree to abide by the By-Laws and this Hospital and in on-call roster arrangements and any terms and conditions which are attached to my appointment.	❑ Yes
I authorise the Credentialing and Scope of Practice Committee to verify with relevant individuals, external organisations and nominated referees the validity of all claims made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history and criminal record.	❑ Yes

ALL SECTIONS MUST BE COMPLETED FOR YOUR APPLICATION FORM TO BE ASSESSED

Signature: ______________________ Date ______________

Witness: ______________________ Date: ______________

Signature

____

Print Name:

CHECKLIST ATTACHMENTS - the following current documents must be provided prior to any consideration of your Application		
Annual Registration Certificate for AHPRA		❑
Professional Indemnity Insurance Certificate		❑
Curriculum Vitae + Qualifications (e.g. Degree, Diplomas etc.)		❑
National Police Certificate	(optional)	❑
Working with Children Check	(optional)	❑

AUTHORITY TO PROVIDE PROOF OF PROFESSIONAL INDEMNITY COVER

It is a condition of your Accreditation at this Hospital that you provide proof of current Professional Indemnity Insurance.

To simplify this process for you can provide us with Authorisation to liaise with your Insurer
by providing the following information to us.

Name on Policy:	
Professional Indemnity Insurer: (e.g. MDA)	
Professional Indemnity Membership Number:	
Professional Indemnity Policy Number:	
Professional Indemnity Insurance – Field of Practice:	

I authorise you to provide proof of my Professional Indemnity Insurance

to Bethesda Hospital [via facsimile: (08) 9340 6399]

on an Annual Basis

For the following period:	
Signature:	
Date:	