

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



CATEGORY FOR ACCREDITATION/CLINICAL PRIVILEGES:

Visiting Medical Practitioner

(Please indicate Scope of Practice)

TERM OF ACCREDITATION/CLINICAL PRIVILEGES:

1 year (initial appointment term for new practitioners)

3 years (approved standard term)

4 months (whilst providing locum services for)

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:

AHPRA 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

SCOPE OF PRACTICE/CLINICAL PRIVILEGES:- PLEASE TICK

<p><input type="checkbox"/> Anaesthesia</p> <p><input type="checkbox"/> Adult</p> <p><input type="checkbox"/> Colorectal Surgery</p> <p><input type="checkbox"/> Laparoscopic Surgery</p> <p><input type="checkbox"/> ENT Surgery</p> <p><input type="checkbox"/> Adult</p> <p><input type="checkbox"/> Head and Neck</p> <p><input type="checkbox"/> General Practitioner</p> <p><input type="checkbox"/> General Surgery</p> <p><input type="checkbox"/> Endoscopic</p> <p><input type="checkbox"/> Laparoscopic Surgery</p> <p><input type="checkbox"/> Gynaecology</p> <p><input type="checkbox"/> General</p> <p><input type="checkbox"/> Oncology</p> <p><input type="checkbox"/> Advanced Endoscopic Surgery</p> <p><input type="checkbox"/> Infectious Diseases</p>	<p><input type="checkbox"/> Ophthalmology</p> <p><input type="checkbox"/> Adult</p> <p><input type="checkbox"/> Oral and Maxillofacial Surgery</p> <p><input type="checkbox"/> Facio Maxillary Surgery</p> <p><input type="checkbox"/> Orthopaedics</p> <p><input type="checkbox"/> Adult</p> <p><input type="checkbox"/> Pain Management</p> <p><input type="checkbox"/> Palliative Care</p> <p><input type="checkbox"/> Registrar</p> <p><input type="checkbox"/> Specialist</p> <p><input type="checkbox"/> Physician Medicine /Internal Medicine</p> <p><input type="checkbox"/> General Medicine</p> <p><input type="checkbox"/> Endocrinology</p> <p><input type="checkbox"/> Geriatrics</p> <p><input type="checkbox"/> Haematology</p> <p><input type="checkbox"/> Microbiology</p> <p><input type="checkbox"/> Neurology</p> <p><input type="checkbox"/> Renal Medicine</p> <p><input type="checkbox"/> Respiratory Physicians</p> <p><input type="checkbox"/> Rheumatology</p>	<p><input type="checkbox"/> Plastic and Reconstructive Surgery</p> <p><input type="checkbox"/> Hand Surgery</p> <p><input type="checkbox"/> Facio Maxillary Surgery</p> <p><input type="checkbox"/> Plastic, Reconstructive and Aesthetic Surgery</p> <p><input type="checkbox"/> Head and Neck</p> <p><input type="checkbox"/> Psychiatry (Consult Only)</p> <p><input type="checkbox"/> General</p> <p><input type="checkbox"/> Sub-specialty (specify):</p> <p><input type="checkbox"/> Radiology</p> <p><input type="checkbox"/> Rehabilitation Medicine</p> <p><input type="checkbox"/> Urology</p> <p><input type="checkbox"/> Adult</p> <p><input type="checkbox"/> Vascular Surgery</p>
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PROFESSIONAL QUALIFICATIONS

Name of Awarding Body	Year Graduated	Copy Attached ✓
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Primary Degree:

Postgraduate Degree(s):

Postgraduate Diploma/Fellowship:

Other Degrees/Diplomas:

Current Professional Association Membership(s):

Clinical audit and/or peer participation	Type of activity	Institution	Date

Do you maintain an Activity Log Book? Yes No

PRACTICE HISTORY

Has your Scope of Practice (clinical activities) changed since you began practicing at this Hospital?

Yes No

If yes, please provide full details of your current clinical activities

Have you been subject to denial, suspension, termination or withdrawal of the right to practice in any other organisation

Yes No

If yes, please provide full details (attach separate page if necessary)

Have you been the subject of disciplinary action or professional sanctions by any registration board, HIC, regulatory authority or similar body?

Yes No

If yes, please provide full details (attach separate page if necessary)

Have you been the subject of any criminal investigation or conviction?

Yes No

If yes, please provide full details (attach separate page if necessary)

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?

Yes No

If yes, please provide full details (attach separate page if necessary)

PLEASE NOMINATE TWO SUBSTITUTE MEDICAL PRACTITIONERS

- * Both must be Accredited to Practice at this Hospital
- * Both must be the same Scope of Practice as Applicant

Name:

Practice Phone No.:

Mobile/Home No.:

Name:

Practice Phone No.:

Mobile/Home 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

The hospital expects all practitioners to comply with the Policy on Blood Borne Viruses. A medical practitioner who is aware that he/she is infected with a blood borne virus should not undertake exposure prone procedures. In the opinion of the Medical Board to do so would prima facie constitute unsatisfactory professional conduct in terms of the *Medical Act 1894*.

I understand and abide by this Standard.

Yes

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 authorise the Hospital to include my details in the Directory which may be distributed to general practitioners in the area.

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 medical indemnity insurance and Medical Board of WA 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 WA Medical Board/APHRA

Professional Indemnity Insurance Certificate

Radiation Safety Act Licence in respect of Irradiating Apparatus and/or Electronic Products

Curriculum Vitae + Qualifications (e.g. Degree, Diplomas etc.)

National Police Certificate

(optional)

Working with Children Check

(optional)

SCOPE OF CLINICAL PRACTICE

PLEASE NOTE:
 Procedures can be subject to prior approval by the Credentialing and Scope of Practice Committee before being performed.
 Any additional procedures from those as advised in this Application
 must be processed and approved by the Credentialing and Scope of Practice Committee before being performed.
 We reserve the right to request further information in relation to any of the above questions.

1. What medical speciality do you wish to practice? (e.g. General Surgery)

2. What routine procedures do you plan to perform? (please provide as much detail as possible)

3. Please indicate if you plan to perform any of the following procedures:

Laparoscopic Hernia Repair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laparoscopic Colectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laparoscopic Splenectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laparoscopic Gastric Banding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laparoscopic Radical Prostatectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you ticked Yes to any of the above boxes, please provide the following evidence:

- Training – date, place, supervisor (evidence of completion of training.

- The number of procedures performed to date – a de-identified list of each procedure and outcomes.

- Your process for ongoing Audit of your outcomes.

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: