Private and Confidential

CREDENTIALING AND SCOPE OF PRACTICE APPLICATION FORM (QLD)

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

NEW APPLICATION ◯ **RENEWAL APPLICATION** ◯

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 WITH *ALL* SUPPORTING DOCUMENTATION TO:

South Brisbane Day Hospital, **Att: Credentialing Officer,** credentialing@sbdh.com.au
87 Ipswich Rd, Wooloongabba Q 4102 Fax: 07 3844 5311

If you are submitting this application within two (2) weeks of your intended start date, please contact the hospital's Credentialing Officer on 07 3239 5090 to ensure your application has been received for processing.

Intended Start Date (if known)		**Location**	◯ South Brisbane Day Hospital ◯ Lady Bjelke-Petersen Community Hospital

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 ◯		**Phone (home)**	
		Mobile Phone	
	Post Code	**Facsimile**	
Email (personal)		**Email (business)**	

Emergency Contact Person

Name		**Relationship**	
Phone (work)		**Phone (home)**	
Phone (mobile)		**Email Address**	
Name of Partner/ Spouse (for Hospital invitation list)			

Provider Details

Provider Number		**Prescriber Number**	

Car Registration Details (For onsite parking - SBDH only)

Licence Plate Number	

Photo Identification

☐ ***Please attach a photocopy of your drivers licence or passport to this application.***

Drivers Licence or Passport Number		**Date of Expiry**	
Issuing State and Country			

Professional Practice Details

Practice Name (1)				
Business Address (Primary Consulting Room) ✉ preferred mailing address ◯			**Phone**	
	Post Code		**Facsimile**	

Practice Name (2)				
Business Address (Other Consulting Rooms) ✉ preferred mailing address ◯			**Phone**	
	Post Code		**Facsimile**	

PROFESSIONAL REGISTRATON DETAILS

☐ ***Please attach a copy of your registration(s) to this application.***

Registration Number		**Expiry Date**	
Category of Registration			

Are there any conditions or undertakings currently attached to this registration? Yes ◯ No ◯

If yes, please provide 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 a copy of your current insurance certificate to this application.***

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.

MEDICO LEGAL*

Are there any current claims for compensation against you or complaints lodged with the Medical Board (or other Registration Board) or Health Quality & Complaints Commission (HQCC)? 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, a Health Care Complaints Commission/Body, 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 the event occurred?

Immunisation Evidence – SBDH requires each new applicant to provide evidence of their current Immunisation Status for: Covid-19, Hepatitis B, Measles, Mumps, Rubella, Varicella, Diphtheria, Tetanus and Pertussis.
☐ ***Please attach a copy of your Immunisation Evidence to this application.***

* This information is required to assess an application for scope of clinical practice and will only be used by South Brisbane Day Hospital / Lady Bjelke-Petersen Hospital for such purposes. Information provided will not be disclosed otherwise.

In case of Emergency - Deputy Medical Officer

Please nominate a Medical Practitioner ***accredited at this 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 of Accredited Nominee	
Specialty	
Contact Number (Mobile Number preferred)	

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

◯ Specialist Medical Practitioner
◯ General Medical Practitioner
◯ Pharmacist
◯ Locum Tenens
◯ Dental Practitioner
◯ Surgical Assistant (no admit rights)
◯ Allied Health Professional
◯ Employed Medical Officer
◯ Nurse Practitioner
◯ Registered Nurse (employed by VMO)
◯ Registered Nurse (working in specialised area)
◯ Dental Assistant

PRIVILEGES SOUGHT (Please tick)

◯ Surgical
◯ Anaesthetic
◯ Surgical Assistant
◯ Allied Health
◯ Procedural
◯ Dental Assistant
◯ Other:

DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED (Please tick)

- ◯ **Anaesthesia**
  - ◯ Adults
  - ◯ Paediatric (8yos and older)
  - ◯ Paediatric (2yos and older)
- ◯ **Dental**
  - ◯ Paediatric
  - ◯ Oral & Maxillofacial
- ◯ **Dermatology**
  - ◯ Adults
- ◯ **Gastroenterology** (LBPCH only)
  - ◯ Endoscopy
  - ◯ ERCP
  - ◯ Other
  - ◯ Adults
- ◯ **Gynaecology** (LBPCH only)
  - ◯ Adults
- ◯ **Urology** (LBPCH only)
  - ◯ Adults
- ◯ **Ophthalmology**
  - ◯ Adults
  - ◯ Paediatric
- ◯ **Oral & Maxillofacial Services**
  - ◯ Facio Maxillary Surgery
  - ◯ Paediatric
- ◯ **Plastic & Reconstructive Surgery**
  - ◯ Adults
  - ◯ Paediatric

OTHER CLINICAL PRACTICE SOUGHT

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

POSTGRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS, COLLEGE OR PROFESSIONAL QUALIFICATIONS

☐ ***Please attach a copy of your current CV to this application.***

Qualification	Date Obtained	Accredited Training Organisation

PRIMARY UNDERGRADUATE QUALIFICATION (List below or attach CV)

Name of University/ Institution	Degree/s	Graduation Year

CONTINUING PROFESSIONAL DEVELOPMENT OVER PAST 3 YEARS - Please include any research activities, funded projects and quality assurance activity.

☐ ***Please attach a copy of your most recent CPD Certificate from your College to this application.***

CONTINUING PROFESSIONAL DEVELOPMENT – National Hand Hygiene Initiative

☐ ***Please attach a copy of your Hand Hygiene Certificate from the National Hand Hygiene Initiative***
https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/national-hand-hygiene-initiative

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 ◯

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)

REFEREES

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. Please note that your referees will be contacted and asked to provide **a written reference**. Telephone referee checks are not conducted.

*** Required Fields**			
(Referee 1) Name*		Email Address*	
Primary Practice Name and Address		Phone	
		Facsimile	
(Referee 2) Name*		Email Address*	
Primary Practice Name and Address		Phone	
		Facsimile	
(Referee 3) Name*		Email Address*	
Address		Phone	
Phone		Facsimile	
(Referee 4) Name*		Email Address*	
Address		Phone	
Phone		Facsimile	

DECLARATION

1. I authorise the South Brisbane Day Hospital (SBDH) and/or the Lady Bjelke-Petersen Hospital (LBPCH), 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.
2. I authorise the SBDH/LBPCH 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 violent offence or any other offence relevant to my practice as a Medical Practitioner.
3. I authorise the SBDH/LBPCH, 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.
4. 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 SBDH/LBPCH if this statement becomes incorrect in the future.
5. 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.
6. 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 SBDH/LBPCH's Medical Advisory Committee may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.
7. I declare that my personal immunisation status is current for preventable diseases including but not limited to Covid-19, Hepatitis B, Measles, Mumps, Rubella, Varicella, Diphtheria, Tetanus, Pertussis, Tuberculosis, Hepatitis A and Influenza. I declare that I will continue to maintain the appropriate immunisation status for the duration of my clinical privileges. I agree to provide confirmation of my immunisation status if so directed by the Medical Advisory Committee.
8. 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 SBDH/LBPCH, including any annexure or variation to the By-Laws during the tenure of my appointment, all relevant legislative requirements (including compliance with Health Ombudsman 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.
9. I undertake to notify the SBDH/LBPCH promptly and in writing, if my scope of clinical practice is altered in any way at any other hospital or day procedure centre.
10. 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 SBDH/LBPCH.
11. I undertake to notify SBDH/LBPCH should any information provided in this application for appointment vary in any way.
12. I understand that it is my responsibility to ensure all surgical assistants attending with me have been approved through the correct credentialing process. Any practitioners not approved will be asked to leave theatre immediately until the necessary checks have been completed by SBDH/LBPCH.
13. I acknowledge and agree to release and indemnify SBDH/LBPCH from and against all claims, including legal costs, out of a decision to suspend or terminate my accreditation or to not re-appoint me in circumstances set out in the Hospital By-Laws.

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 Chief Executive Officer or duly authorised person.

I understand that my Appointment will be reviewed in three (3) years or earlier if considered necessary.

NAME			
SIGNATURE		DATE	
WITNESS NAME			
SIGNATURE		DATE	

CREDENTIALING APPLICATION APPROVAL

OFFICE USE ONLY

PRACTITIONER NAME	

Application Received	Yes ◯ No ◯	CV Received	Yes ◯ No ◯
Copy of Registration Received	Yes ◯ No ◯	Copy of Medical Indemnity Insurance	Yes ◯ No ◯
Copy of CPD Certificate	Yes ◯ No ◯	Relevant References Received	Yes ◯ No ◯
Immunisation Evidence	Yes ◯ No ◯	Hand Hygiene Certificate	Yes ◯ No ◯

Application Presented to MAC	Date:

Interim Privileges Granted	Date:	Comments:

Approved by MAC Chair	Signed:	Date:
Approved by CEO	Signed:	Date:
Approved by Director Anaesthetics	Signed:	Date:
Approved by Medical Specialist Representative	Signed:	Date:

Full Privileges Granted	Date:	Comments:

Approved by MAC Chair	Signed:	Date:
Approved by CEO	Signed:	Date:
Approved by Director Anaesthetics	Signed:	Date:
Approved by Medical Specialist Representative	Signed:	Date:

Application Entered into Hospital IT Management System	Yes ◯ No ◯	Date:
Registration/Insurance Renewal Dates Noted	Yes ◯ No ◯	Date:
Applicant Notified re Interim Privileges	Yes ◯ No ◯	Date:
Applicant Notified re Full Privileges	Yes ◯ No ◯	Date:

Date of withdrawal from licensing register:

Note: To ensure facilities fully comply with the requirement to document the credentialing process, it is recommended that a photocopy of this page be circulated with the agenda and a copy attached to the minutes of the Credentialling Committee meeting at which the application is approved. The completed original of this form should remain with the complete application.