APPLICATION FOR ACCREDITATION

Application for accreditation as a Medical Practitioner

PLEASE TICK THE SITES YOU WOULD LIKE TO APPLY FOR ACCREDITATION

North Shore SPECIALIST DAY HOSPITAL ☐	City West SPECIALIST DAY HOSPITAL ☐	City East SPECIALIST DAY HOSPITAL ☐
North Shore Specialist Day Hospital Chairman Medical Advisory Committee Post: 176 Pacific Highway Greenwich NSW 2065 Fax: 02 9425 1655 Email: admin@nssdh.com.au	**City West Specialist Day Hospital** Chairman Medical Advisory Committee Post: 30 Mons Road Westmead NSW 2145 Fax: 02 9365 4433 Email: admin@cwsdh.com.au	**City East Specialist Day Hospital** Chairman Medical Advisory Committee Post: 225 Maroubra Road Maroubra NSW 2035 Fax: 02 9315 5655 Email: admin@cesdh.com.au

Please submit the completed application form to the primary site of application at
(See above for contact details)

Personal Details:	
Surname of Applicant:	
First Names in full:	
Date of birth (optional):	
Optional: Next of Kin details (in the case of an emergency):	Name: Phone:
Accreditation category:	☐ *Temporary (for a period of no longer than 1 year) from ___/___/___ to ___/___/___* ☐ *Full (5 years, on completion of this period you will be sent a renewal application)*
Accreditation specialty: *(e.g. General, Opthamology, Gastroenterology, Plastics, Anaesthetics)*	

Please tick preferred mailing address:	
☐ Residential Address with postcode: _____ _____ _____	
Home Telephone:	Home Fax:
☐ Primary Professional address with postcode: _____ _____ _____	
Rooms Telephone:	Rooms Fax:
Mobile Number:	Provider No:
Email Address:	
Rooms /Practice Managers Email Address:	Name of Contact /Practice Manager:
Medical Indemnity Number	Medical Registration Number
Working with Children check number(if applicable)	OR Working with children application number (if applicable)
☐ Secondary professional address with postcode: _____ _____ _____	
Rooms Telephone:	Rooms Fax:
Rooms/ Practice Managers Email Address:	Name of Contact /Practice Manager:
☐ Additional professional address with postcode: _____ _____ _____	
Rooms Telephone:	Rooms Fax:
Rooms /Practice Managers Email Address:	Name of Contact /Practice Manager:

Undergraduate qualifications, university and year of graduation:	
Postgraduate qualifications, degrees, diplomas: (Attach CV if insufficient space)	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	
Itemise Postgraduate Educational Activity in the past three years:	
Please list anticipated procedures to be performed at the Specialist Day Hospital/s: _____ _____ _____ _____ _____ _____ _____ _____ _____	

Clinical privileges are sought in the field(s) of:		
For each specialty in which you are seeking privileges, please provide names, addresses and telephone numbers of three peer referees in Australia who can attest to your recent practice and who are not related to you nor financially linked with or financially dependent on you. (Not applicable to surgical assistants)		
Specialty:		
Name of Referee 1:	Name of Referee 2:	Name of Referee 3:
Contact No. & postal address	Contact No. & postal address	Contact No. & postal address
Specialty:		
Name of Referee 1:	Name of Referee 2:	Name of Referee 3:
Contact No. & postal address	Contact No. & postal address	Contact No. & postal address
Please provide photocopy of your current registration		
Are there any conditions attached to this registration?	Yes ☐	No ☐
If Yes, provide details of conditions:		
Please provide photocopy of your Medical Defence Organisation or your Professional Indemnity Insurance Provider:		
Billing less than [insert amount and specialty]	$	

Does your membership fully cover the types of privileges you have applied for?	Yes ☐	No ☐

Appointment at other hospitals or day procedure centres:	
Current/past	
Current/past	
Current/past	

Membership of colleges and/or other relevant Associations:
1. 2. 3. 4.
Any additional information:

Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked or have you had conditions attached to that appointment for any reason?	Yes ☐	No ☐
If Yes, give dates and particulars:		

Please nominate a medical practitioner accredited at the day hospital in your specialty available for contact by the day hospital in case of an emergency if you are unavailable:
Anaesthetists need not nominate a doctor, but must acknowledge the requirement to stay on site at the Specialist Day Hospital until their patients are conscious and safe.

Name:	
Specialty:	
Contact Numbers:	

Specialist Directory:

- I authorize the Day Hospital; to include my details in the Day Hospital Specialist Directory and other marketing activities. Yes ☐ No ☐

Authority:

- I hereby apply for accreditation at the Specialist day Hospital. I have specified with clinical privileges required.
- In making this application I acknowledge and agree:
  - I have received a copy of the Specialist Day Hospital By-Laws.
  - I will abide by the By-Laws.
  - The day hospital executives, its officers and the medical advisory committee(s) may seek information about my past experience, clinical performance and current fitness.
  - I believe there is no further information to disclose which might otherwise prejudice my application for appointment
  - Anaesthetists need not nominate a doctor, but must acknowledge the requirement to stay on site at the Specialist Day Hospital until their patients are conscious and safe.

Name:

_____
Full Name

_____ _____ / _____ / _____
Signature **Date**

Required Attachments:

- ☐ Copy of Medical Indemnity Details **(scope of practice consistent with AHPRA registration)**
- ☐ Copy of Current Resume
- ☐ Copy of Medical Registration- verified on AHPRA website (**registered specialist and conditions checked) (**admin to initial)
- ☐ Copy of Working with Children Check (if applicable)
- ☐ Copy of Current photo identification (verified on first day of operating)
- ☐ Copy of 2 references (**verified and documented by mac Chairperson**)

Please note temporary accreditation is valid for 1 year and full accreditation is valid for 5 years.

RECOMMENDATIONS OF MEDICAL/CLINICAL DIRECTORS		
☐ Temporary privileges recommended	From ___ /___ /___	To ___ / ___ / ___
☐ Full privileges recommended	From ___ /___ /___	To ___ / ___ / ___
☐ Privileges not granted		
Comments		
☐ **References sighted**		
Medical Director Signature:		
APPOINTMENT CONFIRMED BY MAC	Date:	
☐ letter of appointment sent to applicant	Date:	