APPLICATION FOR CLINICAL PRIVLEDGES AT THE MELBOURNE EASTERN PRIVATE HOSPITAL

Name of Medical Practitioner:_____

Type of Application (Please Circle): New Application Renewal/Re-application Altered Scope of Practice

RESIDENTIAL ADDRESS Street, suburb, P/C	
Telephone No.	Prefix [ ] Home: Mobile:
Email Address	
Practice Name/Address Street, suburb, P/C	
Practice Telephone No.	Fax:
Practice Email	Practice Manager:

PROFESSIONAL DATA:

1. Initial Qualification

Degree/Diploma	Issuing Body	Year	Copy Attached?
			Y[] N[] Comment:

2. Additional Qualifications:

Degree/Diploma	Issuing Body	Year	Copy Attached?
			Y[] N[] Comment:
			Y[] N[] Comment:

3. Registration, Insurance Details, and Other Information:

Date of Initiation Registration in Victoria: **Registration No.**	**Provider Number:**	**Do You Have a Prescriber Number: []Y []N** **Prescriber Number:**	**Working With Children Check** (required if working with children) **[]Y []N []N/A** **Do you have a Police Check []Y []N []N/A**

Insurance: Date of Insurance/Expiration _____

Please attach copies of most recent APHRA (or appropriate board) certifications AND a copy of your proof of insurance. Please attach radiation user's license copy if this applies.

- Have there ever been or are there currently pending any claims, settlements or judgements against you? **Yes/No**
- Has your medical, defence organisation ever excluded 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 full explanation of the detail if each matter on a separate sheet and attach.

Medical registration and other matters

What is your Medical Board of Australia registration number? _____

- Is this general registration? **Yes/No**
- Is this specialist registration? **Yes/No**
- If yes, please specify_____
_____.
- Is this limited registration? **Yes/No**

If yes, please specify_____
_____.

Please Circle: Area of need/Public interest/Teaching or research

If you have limited registration, and/or you are to be supervised or under a college peer-review process, please provide details of this process on a separate sheet and attach.

- Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a medical practitioner? **Yes/No**
- Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board either in Australia or elsewhere? **Yes/No**

- Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country? **Yes/No**
- Have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration either in Australia or elsewhere? **Yes/No**
- Have you ever been denied a scope of clinical practice that you requested? **Yes/No**
- Have you ever chosen to reduce your scope of practice? **Yes/No**
- Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body? **Yes/No**
- Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence? **Yes/No**
- Are you the subject of current or pending criminal charges? **Yes/No**

If you answered 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.

- Are you registered as a medical practitioner in any other country? **Yes/No**

If yes, please specify _____

- Have you ever been registered as a medical practitioner in any other country? **Yes/No**

If yes, please specify _____

4. CURRENT PRACTICE:

Please (print clearly) Indicate the type of your current practice/specialty and the types of procedures/care you might engage in while at TMEPH. ***If you are a general practitioner, and your practice involves surgical or specialty procedures – please detail your experience and training therein.***

5. REGISTERED SPECIALTY:

6. CURRENT HOSPITAL APPOINTMENTS (at date of application):

PUBLIC:	

Restrictions? []Y []N Comment:_____

Private:	

Restrictions? []Y []N Comment:_____

7. TYPE OF PRIVILEGES YOU ARE SEEKING:

Note: DOH requires applicants to indicate their desired group and scope of accreditation within that group.

I wish to apply to define my scope of clinical practice to undertake the following - please select from the following groups:	
☐ **Group 1** General Hospital	☐ Management of health service private inpatients ☐ Emergency care ☐ Minor surgery - The Royal Australasian College Of Surgeons' Minor Surgery Course for GPs can be used as a guide in determining relevant procedures ☐ Geriatrics, including residential care
☐ **Group 2** Procedural	☐ Obstetrics ☐ Anaesthetics ☐ Procedural internal medicine ☐ Surgery, other than minor surgery procedures as outlined in Group 1 ☐ Paediatrics
☐ **Group 3** Diagnostic imaging (includes C-Arm and Portable CXR at TMEPH)	Please specify modality/modalities for which scope of clinical practice is sought: Please provide evidence of appropriate radiation licence. (Please refer to guidelines: http://www.health.vic.gov.au/environment/radiation/index.htm)
☐ **Group 4** Non-procedural	Please specify: ☐ Psychiatry ☐ Alcohol and drugs of dependence ☐ Rehabilitation ☐ Palliative care ☐ Public health/infectious diseases ☐ Other/Allied Heath (please provide details)

8. VOLUME AND FREQUENCY OF WORK EXPECTED WITHIN THE FIRST 6 MONTHS:

Please detail anticipated requirements

Admission Frequency:	
Specialised Equipment Required and expected Utilisation	_____ _____

***Please Note**: reviews are done on a regular basis to assess volume, frequency and quality of work to ensure that the hospital can maintain services at a high level for our Visiting Practitioner and patients.*

9. **REFERENCES.** By filling out this form I agree that TMEPH may undertake a reference check, potential criminal background check, and obtain information from other boards, hospitals, insurers and/or other entities in considering this application or should they so require at a future date.

Name & Title of Referee	Full Mailing Address Street Address, Suburb, P/C	Telephone No.	Email Address

10. **IDENTIFICATION (New Accreditations Only): Department of Health, Victoria requires 100 points of ID**. Including Photo Identification. *See attachment. Please provide directly to TMEPH.

***Thank you** for considering my application for accreditation to TMEPH. By completing and signing this form, I agree to adhere to any organizational and/or statutory privacy and confidentiality laws and policies. I agree to co-operate in implementing policies and procedures which are required to provide the highest patient care in accordance with Hospital by-laws, of which I have obtained a copy, Australian Medical Association Code of Conduct and Ethics, TMEPH policies and procedures and compliance to universal and standard precautions. I will not take part in bullying/harassment. I will notify the hospital director immediately should any incident or event take place that could impact my ability to exercise my scope of practice in any way. I agree to notify the Hospital Director immediately should any incident or untoward event take place in my provision of care of patients at TMEPH, or if I become aware of such an event. I also agree to comply with ongoing educational/certification programs, provide annual renewal certificates as required, and to practice within the defined scope of practice and standards of care associated therewith by professional regulatory association(s)/college(s) within The State of Victoria. I understand that breaches could result in the cessation of my appointment.*

Name:_____

Signature: _____ Date: _____

(Requires applicant's own signature)