

**HUNTERS HILL PRIVATE HOSPITAL**

**APPLICATION FOR RE-APPOINTMENT AS AN ACCREDITED PRACTITIONER**

PLEASE ENSURE THIS FORM IS FULLY COMPLETED AND THE FOLLOWING DOCUMENTATION IS INCLUDED WITH THIS APPLICATION:

- Copy of certificate showing participation in Continued Medical Education
- Copy of current Medical Defence Organisation Membership
- Copy of current certificate of Medical Registration
- Copy of AHPRA restrictions (if applicable)

**1. CATEGORY AND SCOPE OF PRACTICE**

I hereby apply to Ramsay Health Care for Re-appointment as an Accredited Practitioner at **HUNTERS HILL PRIVATE HOSPITAL** and seek re-appointment for the category and Scope of Practice indicated. To support my application I submit the following information (Please Print and attach separate sheets if insufficient space):

CATEGORIES	PLEASE TICK	SCOPE OF PRACTICE	PLEASE TICK
CAREER MEDICAL OFFICER		ADMITTING	
CONSULTANT EMERITUS		CONSULTING	
DENTIST		ASSISTING	
FELLOW PRACTITIONER		DIAGNOSTIC	
GENERAL PRACTITIONER		SPECIALIST	
REGISTRAR		OTHER	
SPECIALIST PRACTITIONER			
STAFF SPECIALIST			
SURGICAL ASSISTANT			
OTHER			

SPECIALTY	
SCOPE OF PRACTICE (specify areas of clinical practice applied for including specialty and sub-specialty qualifications and experience)	

NEW SCOPE OF PRACTICE If you are applying for privileges that you have not previously been granted at the Hospital, please state this here and provide details of any additional Post Graduate Qualifications and additional professional associations including College Fellowships. Ramsay Health Care may require that you provide references in relation to the new area.	
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2. PERSONAL DETAILS

NAME			
TITLE: (Dr, Mr, Prof, A/Prof)		SURNAME	
GIVEN NAME		ANY FORMER NAME INCLUDING MAIDEN NAME	
PRESCRIBER NO		PROVIDER NO.	
DATE OF BIRTH			

PERSONAL ADDRESS			
RESIDENTIAL ADDRESS		POSTCODE	
TELEPHONE		PAGER NO.	
FACSIMILE		MOBILE NO.	
EMAIL			

PRACTICE ADDRESS			
PRACTICE ADDRESS		POSTCODE	
POSTAL ADDRESS		POSTCODE	
TELEPHONE		FACSIMILE	
EMAIL			

3. CURRENT APPOINTMENTS

FACILITY	APPOINTMENTS

4. REGISTRATION

PLEASE SUPPLY DETAILS OF YOUR CURRENT REGISTRATION WITH AHPRA OF N.S.W.	
REGISTRATION NO	
SPECIALTY	
PLEASE ATTACH A COPY OF YOUR CURRENT REGISTRATION CERTIFICATE	

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5. INSURANCE

Please refer to Page 10 of the RHC Facility Rules 'Initial Accreditation as a Medical Practitioner or Dentist' Rules 49.2 and 59.2.

Accredited Practitioners should have insurance cover from an Australian Insurer for \$20m each and every \$40m in the aggregate.

Surgical Assistants should have insurance cover from an Australian Insurer for \$10m.

If in doubt, please contact the Hospital CEO to discuss.

DO YOU HAVE CURRENT MEDICAL INDEMNITY INSURANCE AT THE APPROPRIATE LEVEL TO COVER YOUR SCOPE OF PRACTICE?	YES	NO
	<b>PLEASE ATTACH A COPY OF YOUR CURRENT MEDICAL INSURANCE / SCHEDULE</b>	

6. PROFESSIONAL DEVELOPMENT

Please provide details (e.g. courses attended relevant to your appointment) of your compliance with the Continuing Education/Professional Development/Recertification or Maintenance of Standards Program of your College.

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**7. DISCLOSURE**

SINCE YOUR APPOINTMENT (IF THIS IS YOUR 1 <sup>ST</sup> RE-APPOINTMENT) / LAST RE-APPOINTMENT AT THE HOSPITAL			
<b>A</b>	Have you ever had any restrictions placed on your Medical Registration?	YES	No
		<input type="checkbox"/>	<input type="checkbox"/>
<i>(If you answered yes to the above, please provide details (including details of the restriction and period during which the restrictions apply / applied):</i>			
<b>B</b>	Have you previously been refused credentialing at another health care facility?	YES	No
		<input type="checkbox"/>	<input type="checkbox"/>
<i>(If you answered yes to the above, please provide name of the facility &amp; rationale for refusal. Please note: a senior executive of the hospital may contact the facility)</i>			
<b>C</b>	Has your Scope of Practice been restricted, suspended or not renewed on the basis of clinical competency at another hospital?	YES	No
		<input type="checkbox"/>	<input type="checkbox"/>
<i>(If you answered yes to the above, please provide name of the facility &amp; rationale for refusal. Please note, a senior executive of the hospital may contact the facility)</i>			
<b>D</b>	Have there ever been any serious 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 board, a health care complaints commission/body, a coroner, a court or any other professional disciplinary or similar body?	YES	No
		<input type="checkbox"/>	<input type="checkbox"/>
<i>(If you answered yes to the above, please provide details)</i>			
<b>E</b>	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
		<input type="checkbox"/>	<input type="checkbox"/>
<i>(If you answered yes to the above, please provide details)</i>			

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**NSW Applicants Only** - Working with Children

A Working with Children Check is required of applicants in NSW who will be undertaking direct and unsupervised contact with children in the course of their work.

Are you likely to be undertaking child related work meeting the definition above?	YES	No

If you answered yes to the above question, do you consent to make a prohibited Employment Declaration and a Background Check, as prescribed by the relevant law?	YES	No

**8. NOMINATION ALTERNATIVE IN EVENT OF EMERGENCY**

In the event that I am unable to be contacted for a clinical emergency, the person nominated below is an appropriately qualified Accredited Practitioner who has agreed to deputise for me:

NAME	
CONTRACT PHONE NUMBERS	

**9. CONFIRMATION:**

I confirm that the information contained in this document is true and accurate 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 Board of Ramsay Health Care Pty Limited may (in its absolute discretion) consider that I do not have "current fitness" under the RHC Facility Rules.

I agree that I will notify the CEO of [Hunters Hill Private Hospital](#) of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I understand that my Appointment as an Accredited Practitioner if granted will be reviewed in five years or earlier if considered necessary.

I acknowledge that I have been provided with and read a copy of the RHC Facility Rules. If appointed, I agree to abide by the RHC Facility Rules and [Hunters Hill Private Hospital](#) policies.

Signature:		Date:	
Witness Name:		Date:	
Witness Signature:			

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