



Credentialing and Scope of Clinical Practice Application Form

Application for appointment and scope of clinical practice for an accredited practitioner. Please type or print, tick all relevant boxes and sign the form.

PRIVATE & CONFIDENTIAL

<input type="checkbox"/> NEW APPLICATION <i>Must be accompanied by Curriculum Vitae, proof of AHPRA registration and professional indemnity insurance, and two written references</i>
<input type="checkbox"/> RENEWAL APPLICATION <i>Application form only</i>

Preferred Title	
Given Names	
Preferred Name	
Surname	
Previous Name	
Date of Birth	
Home Address	
<input type="checkbox"/> Mailing address	
Preferred contact number	
Email (business)	
Email (personal)	
Emergency Contact Person	
Relationship	
Practice Name (1)	

Business Address <input type="checkbox"/> Mailing address			
Practice Name (2)			
Business Address <input type="checkbox"/> Mailing address			
Name of Partner/Spouse (for Clinic invitation list)			
AHPRA REGISTRATION			
Registration Number			
Category			
Are there any conditions or undertakings currently attached to this registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been registered as a medical practitioner in another country?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, please give details:</i> 			
Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board or other registration board in Australia or another country?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, please give details:</i> 			
PROFESSIONAL INDEMNITY			
Indemnity Insurance Company			
Indemnity Insurance Number			
Category of Coverage		Expiry date	/ /

Does your membership fully cover the scope of clinical practice you have applied for?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your medical defence insurer or any medical defence insurer or fund which you have been a member ever applied conditions or refused to renew your cover or membership in part or full?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any current claims for compensation against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any complaints lodged with AHPRA or the Health Ombudsman?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please give details:</i>		
CATEGORY OF CLINICAL PRACTICE SOUGHT		
<input type="checkbox"/> Specialist Medical Practitioner <input type="checkbox"/> General Medical Practitioner <input type="checkbox"/> Allied Health Practitioner		
PRIVILEGES SOUGHT		
<input type="checkbox"/> Admitting <input type="checkbox"/> Consulting <input type="checkbox"/> Procedural (rTMS or ECT)		
SCOPE OF CLINICAL PRACTICE BEING SOUGHT		
<input type="checkbox"/> Psychiatry – General adult and ECT (Level 5) <input type="checkbox"/> General Medicine Consulting		
REFEREES		
Referee 1	Name:	
	Current Position:	
	Address:	
	Phone:	Fax:
	Mobile:	
	Email:	
	Relationship:(i.e. Line manager, Professional Peer etc)	
Referee 2	Name:	
	Current Position:	
	Address:	

	Phone: Fax:
	Mobile:
	Email:
	Relationship:(i.e. Line manager, Professional Peer etc)

CLINICAL APPOINTMENTS

<i>Organisation</i>	<i>Appointment</i>	<i>Dates</i>
		to
		to
		to
		to
		to
		to
		to
		to
		to
		to

PROFESSIONAL AFFILIATIONS

Are you a member of any specialist Colleges or Associations? <i>Please list</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CONTINUING PROFESSIONAL DEVELOPMENT & QUALITY		
Have you met the continuing professional development requirements of the Medical Board of Australia or other relevant Board (allied health)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you participated in regular clinical reviews, audits and or peer review activities in the clinical setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you prepared to conduct grand rounds or other educational activities at The Toowoomba Clinic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH STATUS		
Do you have a disability or health issues that:		
<ul style="list-style-type: none"> May impact on your ability to perform any of the cognitive or physical functions that would fall within the scope of practice that you are seeking in this application? 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May require special equipment, facilities of work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DECLARATION AND AGREEMENT		
I understand that The Toowoomba Clinic in assessing my application for appointment as a medical practitioner or allied health practitioner, The Toowoomba Clinic will make additional enquiries as to my suitability for the position.		
I understand The Toowoomba Clinic will conduct a routine police check.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I authorise The Toowoomba Clinic to seek information from my referees as to my past experience, performance and current fitness to practise.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I agree to familiarise myself with the relevant hospital by-laws, policies and procedures and abide by them.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I accept that the health service will obtain information relevant to my application from the Medical Board of Australia or any other authority that regulates health practitioners.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I authorise The Toowoomba Clinic to obtain information relevant to my application from my current and any previous medical or professional indemnity organisation/insurer.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I authorise The Toowoomba Clinic to obtain information relevant to my supervision requirements (where applicable).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I authorise The Toowoomba Clinic to seek information from other persons as The Toowoomba Clinic considers appropriate, including any relevant health service, college or other professional organisation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I agree to abide by the organisation's and State and National confidentiality and privacy laws and policies and understand that breaches may result in cessation of my appointment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I agree to notify the CEO/DON, The Toowoomba Clinic of any event or situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the Clinical Director would wish to be informed and as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I agree to support and participate in The Toowoomba Clinic's performance development activities.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I agree to promptly notify the CEO/DON, The Toowoomba Clinic of any adverse clinical incident I am involved in or become aware of.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand that my appointment will be reviewed in one (1) year and five (5) years for re-appointments or earlier as considered necessary.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Declaration I hereby declare that the information contained in this application is true and correct.</p> <p>Signature of Applicant Date: / /</p>		
<p>Witness Signature:</p> <p>Witness Name:</p> <p>Date:</p>		

OFFICE USE ONLY**Applicant Name:****Checklist**

Proof of identification • Sight certified copy of identification documents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact details • Confirm on identification documents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider Number	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescriber Number	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Registration • Sight certified copy of registration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Indemnity Insurance cover currency • Sight certified copy of current medical indemnity insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Qualifications • Sight certified copy of qualifications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appointments • Verify with previous employers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Referees • Referees recent, reflect CV • Contacted referees and verified referee reports	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Curriculum Vitae attached • Confirm previous appointments, referees	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Continuing professional development	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signed declaration	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Application checked by:	
Signature:	
Date:	
Letter to applicant advising of outcome of application	<input type="checkbox"/> Yes <input type="checkbox"/> Copy attached