PERTH CLINIC

APPLICATION FOR APPOINTMENT AS AN

ACCREDITED PRACTITIONER

Please ensure this form is fully completed and the following documentation is included with this application:

- ❒ Copy of Curriculum Vitae
- ❒ Copy of Evidence of qualifications / medical education
- ❒ Copy of AHPRA Certificate of Registration
- ❒ Copy of Receipt of payment and certificate of currency of current indemnity cover

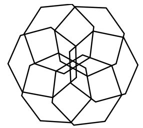
You can apply for either ***'Long Term Accreditation'*** (a period of up to 3 years) or ***'Temporary Accreditation'*** (a period of up to 30 days). All Accreditation applications are used in conjunction with the Perth Clinic By-Laws and Code of Conduct.

You are applying to Perth Clinic for appointment as an Accredited Practitioner and seek appointment for the category and Scope of Practice indicated on this application form.

Please note your application and supporting documentation will be forwarded to the Medical Credentials Committee at Perth Clinic who will be asked to provide a recommendation regarding your application.

perth Clinic

NEW APPLICATION FOR ACCREDITATION



Title: ❐ Dr ❐ Mr ❐ Mrs ❐ Ms ❐ Miss ❐ Other ____

Given Name(s): ____

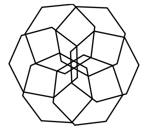
Surname: ____

ACCREDITATION SOUGHT ***(please tick one):***
❐ **Long Term Accreditation** *(a period of up to three years)* **OR**
❐ **Temporary Accreditation** *(a period of up to thirty days)*

CLINICAL PRACTICE IS SOUGHT IN THE FOLLOWING CATEGORIES ***(please tick those that apply):***	
❐	**General Practitioner**
❐	**Physician**
❐	**Anaesthetist**
❐	**Consultant Psychiatrist**
Please specify area/s of specialty / interest/s:	

CREDENTIALED TO ***(please tick those that apply):***
❐ **Admit Patients**
❐ **Consult**
❐ **Perform ECT Treatment**

CONTACT DETAILS:		
Date of Birth:	**Provider No:**	
Private / Residential Address: ❐ *please tick if preferred mailing address*	Post Code:	
Home Number:	Mobile Number:	
Email Address:		
Primary Practice Address: ❐ *please tick if preferred mailing address*	Post Code:	
Phone Number:	Fax Number:	
Email Address:	Provider Number:	
Preferred Method of Contact ***(please circle)*****:**	Email	Postal Address



PROFESSIONAL REGISTRATION DETAILS

It is a requirement of Accredited Practitioners at Perth Clinic that you must be registered to practice and carry professional indemnity insurance cover issued by an Australian insurer relevant to your practice. Perth Clinic policy requires that all Accredited Practitioners hold a minimum level of cover of $20 million for each claim and in the aggregate. Please provide copies of, or information on:

- AHPRA certificate of registration (which must show that your registration is current and unconditional);
  AND
- Receipt of payment of current indemnity cover together with the name of your insurer, and the amount for which you are insured.

Note: In the event that your application is successful, each year Perth Clinic will seek evidence of current registration and indemnity cover. Failure to provide this will result in loss of Accreditation and clinical privileges.

AHPRA Registration Number: ________________________________ **Expiry:** __________________________

Registered as ____ *(insert relevant area of practice, if seeking to practice a specialist you must be registered in that speciality).*

Medical Indemnity Insurance Company:	**Medical Indemnity Insurance Number:**

PROFESSIONAL QUALIFICATIONS		
Primary Undergraduate Qualification *(List below or attach CV)*		
Name of University / Institution	Degree/s	Graduation Year:
Postgraduate Qualifications, Degree/s, Diploma/s, or Professional Qualifications *(List below or attach CV)*		
Qualification	Date Obtained	Accredited Training Organisation

AWARDS AND DECORATIONS

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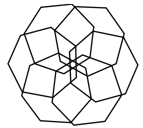

PRESENT HOSPITAL APPOINTMENTS (PUBLIC & PRIVATE)	
Hospital	**Appointment**

RESEARCH

Are you presently undertaking any research projects? ❒ **Yes (please specify)** ❒ **No**

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CURRENT MEMBERSHIP OF PROFESSIONAL ASSOCIATIONS

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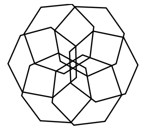
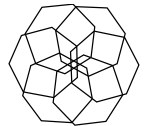
PUBLICATIONS		
Title	Date Published	Name of Publication



DISCLOSURE
Have you ever had any restrictions / conditions placed on your Medical Registration and / or Medical Indemnity Insurance? ❐ **Yes (please specify)** ❐ **No** ____________________ ____________________ ____________________ ____________________ ____________________
Have you previously been refused credentialing at another health care facility? 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).*** ❐ **Yes (please specify)** ❐ **No** ____________________ ____________________ ____________________ ____________________ ____________________
Has your scope of practice been restricted, suspended or not renewed at any other health care facility? 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).*** ❐ **Yes (please specify)** ❐ **No** ____________________ ____________________ ____________________ ____________________ ____________________
Are you currently under investigation or 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 (please specify)** ❐ **No** ____________________ ____________________ ____________________ ____________________ ____________________

NOMINATED ALTERNATIVE ACCREDITED PRACTITIONER IN THE EVENT OF EMERGENCY	
In the event that I am unable to be contacted for a clinical emergency, the person nominated below is a Perth Clinic Accredited Practitioner who has agreed to deputise for me:	
Name:	
Telephone / Mobile:	
I acknowledge that the doctor named above is aware that they have been nominated as my emergency contact (please tick) ❐	



REFEREES		
Please provide the names, addresses, telephone numbers and email addresses of two (2) referees from whom Perth Clinic may seek details of your experience and skills. It is advisable that your referees have worked closely with you for a reasonable period during the past five years, that one is from your own discipline and the other is presently accredited to Perth Clinic. You authorise your referees to release any relevant information to Perth Clinic or its nominated representative. The Executive Committee may seek references from persons other than those nominated by you if it so wishes.		
REFEREE #1		
Name:		
Address:		
Telephone:		**Fax:**
Mobile:		
Email:		
Perth Clinic Accreditation:	❒ Yes ❒ No	
REFEREE #2		
Name:		
Address:		
Telephone:		**Fax:**
Mobile:		
Email:		
Perth Clinic Accreditation:	❒ Yes ❒ No	

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.

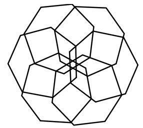
I understand that if I have provided misleading or deceptive information or information which is likely to mislead or deceive, that the Board of Perth Clinic may (in its absolute discretion) consider that I do not have “current fitness” under the By-Laws.

I authorise Perth Clinic, its Executive Committee and Medical Advisory Committee to seek information as to my past experience, performance and current fitness to practice medicine. I agree to provide such further information and evidence relevant to my application which may be required by the Executive Committee or the Medical Advisory Committee.

I agree that I will notify the CEO of Perth Clinic of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I acknowledge that I have received and read the Perth Clinic By-Laws and Code of Conduct. If appointed I agree to abide by the requirements set out in these documents.

Signature: ____________________________________ **Date of Application:** ______________________



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CREDENTIALING COMMITTEE

Date Application Received:

First reference received: ❒ Yes ❒ No

Second reference received: ❒ Yes ❒ No

Comments from Other Committee Members:

Suitable for Accreditation?

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Recommendations:

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FOR OFFICE USE ONLY

Temporary Accreditation Granted:

❒ Yes ❒ No ❒ N/A **Expiry Date:** ___________________________

CEO's Signature: ____ **Date:** ____________________________

ECT Scope of Practice Confirmed by Medical Director - ECT:

❒ Yes ❒ No ❒ N/A

MD - ECT Signature: _______________________________________ **Date:** ____________________________

Credentials Committee Recommendation:

❒ Approved ❒ Not Approved ❒ Deferred Decision

Chairperson's Signature: __________________________________ **Date:** ____________________________

Medical Advisory Committee Recommendation:

❒ Approved ❒ Not Approved ❒ Deferred Decision

Chairperson's Signature: __________________________________ **Date:** ____________________________

Executive Committee Approval:

❒ Approved ❒ Not Approved ❒ Deferred Decision

CEO's Signature: ____ **Date:** ____________________________