Application for Clinical Privileges

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| **Personal Details**  Family Name | | | Given Name(s) | | |
| Business Address | | | | | |
|  | | | Postcode | | |
| Private Address | | | | | |
| Postcode | | | Email | | |
| **Telephone**  Business: | Home: | | | Mobile: | |
| Date of Birth: | | | Gender: M  F  | | |
| **Qualifications**:  Degree/Fellowship etc. | | University/College etc | | | Year of Qualification |
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| **Papers Published/Presentations/Special Interests:** | | | | | |
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| **Registration:**  Are you currently registered to practice with AHPRA? Yes  No   If Yes quote registration number (attach copy) | | | | | |
| **Professional indemnity insurance:**  Are you currently a member of a Medical Defence organisation? Yes  No   If Yes provide a copy of type and scope of current insurance (attach copy) | | | | | |
| **Details of specific scope of clinical practice requested**: | | | | | |
| **Paediatric Experience (if applicable):** | | | | | |
| **Any other organisation where clinical privileges have been achieved**: | | | | | |
|  | | | | | |
| Nominated backup practitioner: | | | | | |
| Are you currently involved in clinical audit, peer review activities &/or continuing medical education: Yes No | | | | | |
| If Yes are you prepared to continue to do so?  Yes No | | | | | |
| Have you ever had clinical privileges denied, limited or withdrawn?  Yes No | | | | | |
| If Yes please give details (attach sheet) | | | | | |
| Have you any physical or other condition which may limit your ability to practice your discipline?  Yes No  | | | | | |
| If Yes comment: | | | | | |

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| **References** (3 professional referees required): | | | |
| **Name:** | **Address:** | **Phone No:** | **Fax No:** |
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| **Clinical activity:**  Provide a summary of clinical activity undertaken at all health care facilities within the past 12 months & where available, objective data on the outcomes of that clinical activity (attach sheet) | | | |
| **I declare that I am unaware of:**   1. any prior disciplinary action or professional sanctionsimposed by any Medical Board; 2. any prior change to the defined scope of clinical practice; 3. any other organisation prior denial, suspension, termination or withdrawal of the right to practice (other than for organisational need and/or capability reasons); 4. any criminal investigation or conviction; 5. The presence of any physical or mental condition or substance abuse problem that could affect the medical practitioner’s ability to exercise the requested scope of clinical practice or that would require any special assistance in order to enable the medical practitioner to exercise that scope of clinical practice safely and competently. | | | |
| **Operating List Preference:**  Please specify preferred operating day: Mon – Fri \_\_\_\_\_\_\_\_ AM/PM \_\_\_\_\_\_  Intended start date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | |

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Attachments List**

1. AHPRA Registration
2. Medical Indemnity Insurance
3. Copies or other evidence of qualifications detailed in the application form
4. Curriculum vitae should be attached in support of this application.

For Office Use:

Reviewed by MAC on: \_\_\_/\_\_\_/\_\_\_\_\_\_

Approved for clinical privileges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Letter of appointment sent: \_\_/\_\_\_/\_\_\_\_\_