THE SYDNEY PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

63 Victoria Street, ASHFIELD NSW 2131
**ABN 97 094 662 914**
Tel (02) 9797 0555 Fax (02) 9798 8561

# CREDENTIALING APPLICATION FOR VISITING PRACTITIONER (VP) RIGHTS

**1. SPECIALTY APPLYING FOR:**_____

***1.1*** PLEASE PROVIDE A LIST OF PROCEDURES plus your scope of practice YOU INTEND TO PERFORM. (***ADDITIONAL SHEETS OF PAPER CAN BE ATTACHED, IF REQUIRED).***

_____

_____

**2. QUALIFICATIONS:**

_____

_____

**3. DATE OF APPLICATION:** _____

**4. FULL NAME:**_____ 5. **DATE OF BIRTH:**_____

**6. PRESCRIBER NO:**_____ **7. PROVIDER NO.:**_____

**8. PRESENT HOSPITAL APPOINTMENTS**

Public: _____

Other Hospitals to which you admit patients _____

**9. ADDRESS:**

9.1 PROFESSIONAL:_____

_____

POSTAL:_____

TELEPHONE:_____FAX:_____

MOBILE:_____

EMAIL:_____

9.2 RESIDENTIAL: _____

_____TELEPHONE:_____

**10. MEDICAL INDEMNITY INSURANCE:** **DATES OF COVERAGE:** _____
(Please supply copy)

10.1 HAVE THERE EVER BEEN OR ARE THERE CURRENTLY PENDING ANY CLAIMS, SETTLEMENTS OR JUDGEMENTS AGAINST YOU? **YES / NO**

10.2 HAS YOUR MEDICAL DEFENCE ORGANISATION EVER EXCLUDED ANY SPECIFIC AREA OF PRACTICE, OR TERMINATED OR DENIED COVERAGE? **YES / NO**

**11. DISCIPLINARY ACTIONS:**

11.1 HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY ACTION IN THE COURSE OF YOUR WORK AS A MEDICAL PRACTITIONER? **YES / NO**

11.2 HAVE YOU EVER BEEN CONVICTED OF ANY CRIMINAL CHARGES (OTHER THAN MOTOR VEHICLE OFFENCES)? **YES / NO**

11.3 HAVE YOU EVER BEEN CONVICTED OF A DRUG OR ALCOHOL RELATED OFFENCE? **YES / NO**

11.4 HAS YOUR ACCREDITATION EVER BEEN REVOKED FROM ANOTHER HOSPITAL?

**IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAIL OF EACH MATTER ON A SEPARATE SHEET AND ATTACH.**

**12. DETAILS OF AHPRA REGISTRATION:**

**12**.1 Initial Date of Registration in NSW ___ / ____ / ____ Registration No._____
(Please supply copy)

**13. PROOF OF ID:**

**13.1 Working With Children (WWCC). Apply for your working with children check** https://wwccheck.ccyp.nsw.gov.au/Applicants/Application# copy and paste this address into your address bar of internet explorer)

**13.2 Photo ID** ☐ **13.2 Police Check** ☐

**14. REFEREES: (Please attach references from (2) Medical Practitioners. Both letters must be on letterhead and one referee must be in your specialty group.)**

**Surgical Assistants who require Accreditation for a short term (less than 6 Months) will only require a reference from the Surgeon they will be working with.**

Name _____Position:_____

Address: _____Phone:_____ Fax:_____

Name _____Position:_____

Address: _____Phone:_____ Fax:_____

**15. COPY OF ACCREDITED LASER CERTIFICATE** **YES** ☐ **NO** ☐ **N/A** ☐

**16. COPY OF ACCREDITED RADIATION CERTIFICATE** **YES** ☐ **NO** ☐ **N/A** ☐

**17. COPY OF GESA RECERTIFICATION CERTIFICATE** **YES** ☐ **NO** ☐ **N/A** ☐

**18.** I AM AWARE THAT SHOULD THIS APPLICATION BE SUCCESSFUL THAT COMPLIANCE WITH THE RELEVANT BY-LAWS, OCCUPATIONAL HEALTH & SAFETY POLICIES AND RULES AND REGULATIONS OF THE SYDNEY PRIVATE HOSPITAL – ASHFIELD IN SO FAR AS THEY RELATE TO THIS POSITION, WOULD BE EXPECTED.

I AM AWARE THAT I MUST TAKE REASONABLE STEPS TO KNOW MY OWN INFECTIOUS DISEASE AND VACCINATION STATUS (AT MY OWN COST) AND MINIMISE THE RISK OF TRANSMITTING INFECTIOUS DISEASES.

**A COPY OF THE BY-LAWS, RULES AND REGULATIONS WILL BE SUPPLIED WITH THIS APPLICATION.**

**19. I ACCEPT AND AGREE TO ABIDE BY THE CURRENT BY-LAWS POLICIES AND ALL REVISIONSISSUED AS NECESSARY BT THE SYDNEY PRIVATE HOSPITAL – ASHFIELD.**

**20. SIGNATURE OF APPLICANT: _____ Date: _____**

## 21. HOSPITAL USE ONLY:

**21.1 References Checked: ___**
**If reference emailed, send email to the referee verifying that the reference was sent from them.**

**21.2 Registration checked: ___**

**21.3 Insurance checked: ___**

**21.4 Working with Children Checked: ___**

**21.5 Relevant Education Certificates provided (e.g. hand hygiene) ___**

**21.6 Radiation Licence provided (if applicable): ___**

**21.7 GESA Recertification Certificate (if applicable) ___**

**21.8 Approved by Hospital Director: _____ Date: __ __ / __ __ / _____**

**21.9 21.9.1 Submitted & approved to Medical Advisory Chairman:**

_____
**(print name)**

**21.9.2 Submitted & approved to Medical Advisory Chairman:**

_____
**(signature)**

**21.9.3 Submitted & approved to Medical Advisory Chairman:**

_____
**(date)**

**21.10 21.10.1 Submitted & approved to MAC Committee member:**

_____
**(print name)**

**21.10.2 Submitted & approved to MAC Committee member:**

_____
**(signature)**

**21.10.3 Submitted & approved to MAC Committee member:**

_____
**(date)**

**21.11 Applicant notified: ____**

**21.12 WWCC verified online check.**

| Date | WWCC Number | Birth date | Expiry date |
|---|---|---|---|
| | | | |

**21.13 CONDITIONS**

| | | | | |
|---|---|---|---|---|
| **21.13.1** | **Conditions noted.** | **YES** | **NO** | |
| **21.13.2** | **Conditions sighted by MAC Chairman.** | **YES** | **NO** | |
| **21.13.3** | **Conditions approved by corporate Executive of MHC for final approval.** | **YES** | **NO** | |