

APPLICATION FORM

Application for Credentialling and Privileging (defining scope of Clinical Practice) for Visiting Medical Officers

Executive Summary

It is essential that all medical practitioners who have independent responsibility for patient care and who are appointed to St Andrews Toowoomba Hospital are appropriately credentialled and privileged (have their scope of clinical practice defined) in accordance with both their level of skill and experience and the capability of the Hospital.

The Australian Council for Quality and Safety in Health Care has developed a national standard to guide this important process: *Standard for credentialling and defining the scope of clinical practice, July 2004 (the 'National Standard')*.

Definitions

Credentialling, defining the scope of clinical practice (privileging) and appointment have been defined in the National Standard as:

Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality healthcare services within specified organisational environments.

Defining the scope of clinical practice follows on from credentialling and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice.

Appointment is defined as the employment or engagement of a medical practitioner to provide services within an organisation according to conditions defined by general law and supplemented by contract.

APPLICATION FOR RE-CREDENTIALLING AS A VISITING MEDICAL OFFICER



PERSONAL DETAILS

Title: _____ Surname: _____

Given Names: _____

Date of Birth: ____/____/____

Private Address: _____

Professional Address: _____

TELEPHONE CONTACT DETAILS

Professional: _____ Private: _____

Mobile: _____ Facsimile: _____

Pager: _____

Email: _____

Order of numbers to be contacted after hours: _____

Name of Partner/Spouse (for Hospital Invitation List): _____

QUALIFICATIONS

Field of Practice: _____

Special Privileges Required (eg laparoscopic) _____

Qualifications (include where and when obtained): _____

Details of Post Graduate Formal Instruction and/or supervised training undertaken: _____

REGISTRATION DETAILS

Current Medical Board Registration Number: _____

INSURANCE

Details of current professional indemnity insurance and professional indemnity claims history:

CLINICAL EXPERIENCE

Details of past experience (include details of service at other institutions and past and current clinical appointments): _____

INVESTIGATIONS OR ENQUIRES

1) Details of any investigation or enquiry pursuant to the Medical Act 1939 or by a Medical College into the applicants practice and the outcome of such investigation or enquiry: _____

2) Disclosure about disciplinary actions/criminal activity. Have you ever been the subject of disciplinary action in the course of your practical work as a medical practitioner?

Yes No

If yes, please describe: _____

QUALITY OF CARE

Do you have a disability/health impairment that might compromise your ability to perform any of the cognitive and physical functions related to the clinical work you may be required to perform?

Yes No

If yes, please describe:

GENERAL

Any further information that maybe relevant to the application: _____

If you require any further space to answer any questions, please attach separate pages, identified with the relevant section number.

I have read and understood the By-Laws and Professional Guidelines for Medical Practitioners and Allied Health Professionals, the Medical Act 1939 (as amended) and the code of conduct of any medical college of which I am a member. I agree to abide by the By-Laws, Medical Act, and code of conduct in every respect. The information provided above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Please supply a photocopy of your current registration and malpractice insurance

Hospital use only

- 1. Details Updated
- 2. Declaration signed

Signature: _____

Date: _____

Decision of Credentialling and Clinical Privlidges Committee at its meeting on

Date: _____

Application Approved Rejected

If Application rejected, detail reasons:

Letter to Applicant advising outcome of application Yes

Copy attached