

## GENERIC CREDENTIALING AND SCOPE OF PRACTICE APPLICATION FORM

*Developed by members of the Private Hospitals Association of Queensland Inc. - 2007*

**Private and Confidential**

<b>APPLICATION FOR INITIAL APPOINTMENT AND SCOPE OF CLINICAL PRACTICE AS AN ACCREDITED PRACTITIONER</b>
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PLEASE PRINT OR TYPE, TICK RELEVANT BOXES, AND SIGN THE FORM.

PLEASE RETURN THE FORM WITH A COPY OF YOUR CURRICULUM VITAE, PROOF OF REGISTRATION AND PROFESSIONAL INDEMNITY TO:



Executive Assistant  
Executive Office  
St Andrew's Toowoomba Hospital

Telephone: 07 4631 4607  
Facsimile: 07 4634 9117

PERSONAL AND CONTACT INFORMATION			
<b>Surname</b>		<b>Given Names</b>	
<b>Preferred Title</b> <small>(e.g. Dr, Mr, A/Prof; Prof)</small>		<b>Preferred Name</b>	
<b>Any former names, including maiden name</b>		<b>Date of Birth</b>	
<b>Home Address</b>  <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	PCode	<b>Phone (home)</b>	
		<b>Mobile Phone</b>	
		<b>Pager</b>	
		<b>Facsimile</b>	
<b>Email (personal)</b>		<b>Email (business)</b>	
<b>Emergency Contact Person</b>		<b>Relationship</b>	
<b>Phone (work)</b>		<b>Phone (home)</b>	
<b>Phone (mobile)</b>		<b>Preferred telephone contact order</b>	
<b>Provider Number</b>		<b>Prescriber Number</b>	
<b>Name of Partner/ Spouse</b> <small>(for Hospital invitation list)</small>			
PROFESSIONAL PRACTICE DETAILS			
<b>Practice Name (1)</b>			
<b>Business Address</b> <small>(Primary Consulting Room)</small>  <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	PCode	<b>Phone</b>	
		<b>Facsimile</b>	
<b>Practice Name (2)</b>			
<b>Business Address</b> <small>(Other Consulting Rooms)</small>  <input type="checkbox"/> preferred mailing address <input type="checkbox"/>	PCode	<b>Phone</b>	
		<b>Facsimile</b>	

<b>QUEENSLAND REGISTRATION DETAILS</b> (Please attach copy of your Registration certificate)			
<b>Registration Number</b>		<b>Expiry Date</b>	
<b>Category of Registration</b>			
Are there any conditions or undertakings attached to this registration? If yes, please give details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board/dental board (as appropriate)? If yes, please give details of the restriction and what period during which the restrictions apply/applied.			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HEALTH QUALITY AND COMPLAINTS COMMISSION (HQCC)</b>			
Have you completed all relevant HQCC Self Assessments?			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>PROFESSIONAL INDEMNITY</b> (Please attach copy of your professional indemnity certificate)			
<b>Indemnity Insurance Number</b>		<b>Category of Coverage</b>	
<b>Insurance Company</b>			
Does your membership fully cover the scope of clinical practice you have applied for?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your medical defence union or any medical defence union or fund of which you have been a member ever applied conditions or refused to renew your cover or membership? If yes, please provide details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
Are there any current claims against you with your Insurer, Medical Board or Health Quality & Complaints Commission (HQCC)? If yes, please provide details.			Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
<b>Criminal Record Check</b> – Have you been convicted of, or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)?  If yes, and if not prevented by confidentiality agreements, could you please provide a brief description of each adverse judgement or settlement, and the year in the event occurred?			Yes <input type="checkbox"/> No <input type="checkbox"/>
* This information is required to assess an application for scope of clinical practice and will only be used by XSt Andrew's Toowoomba Hospital for such purposes. Information provided will not be disclosed otherwise.			
Please nominate a Medical Practitioner accredited at the Hospital in your Specialty available for contact by the Hospital in the case of an emergency if you are unavailable, and who has agreed to deputise for you.			
<b>Name</b>			
<b>Specialty</b>			
<b>Contact Number</b>			

**FOR SURGICAL ASSISTANT APPLICANTS ONLY:**

Name of Accredited Health Professional at each applicable hospital who will provide a reference for you

<b>Name:</b>	<b>Contact No:</b>	<b>Hospital:</b>
<b>Name:</b>	<b>Contact No:</b>	<b>Hospital:</b>
<b>Name:</b>	<b>Contact No:</b>	<b>Hospital:</b>
<b>Name:</b>	<b>Contact No:</b>	<b>Hospital:</b>

CLINICAL PRACTICE SOUGHT IN THE FOLLOWING CATEGORY(S) (Please tick)				
<input type="checkbox"/> Specialist Practitioner <input type="checkbox"/> General Practitioner <input type="checkbox"/> Dentist	<input type="checkbox"/> Consultant Emeritus (no admitting rights) <input type="checkbox"/> Consultant Staff Specialist (no admit rights) <input type="checkbox"/> Salaried non-specialised Medical Officer	<input type="checkbox"/> Surgical Assist (no admit rights) <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Clinical Fellow		
<input type="checkbox"/> Admitting Privileges <input type="checkbox"/> Assist Privileges <input type="checkbox"/> Surgical Privileges		<input type="checkbox"/> Consulting Privileges <input type="checkbox"/> Anaesthetic Privileges <input type="checkbox"/> Diagnostic Privileges <input type="checkbox"/> Under direct supervision <input type="checkbox"/> Other		
DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED: (Not applicable to Surgical Assistants) (Please tick)				
<input type="checkbox"/> Anaesthesia <input type="checkbox"/> Adults <input type="checkbox"/> Neonatal <input type="checkbox"/> Obstetric <input type="checkbox"/> Paediatric <input type="checkbox"/> Cardiology <input type="checkbox"/> Interventional Procedures <input type="checkbox"/> Diagnostic Procedures <input type="checkbox"/> EPS <input type="checkbox"/> Paediatric Procedures <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Dental <input type="checkbox"/> Oral & Maxillofacial <input type="checkbox"/> Dermatology <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Endocrinology <input type="checkbox"/> Adults <input type="checkbox"/> Paediatric <input type="checkbox"/> ENT Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Paediatric Endoscopic <input type="checkbox"/> Head and Neck <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Endoscopy <input type="checkbox"/> ERCP <input type="checkbox"/> General Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Endoscopy <input type="checkbox"/> Laparoscopic Surgery <input type="checkbox"/> Intensive Care <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric	<input type="checkbox"/> Neonatology <input type="checkbox"/> Category 1 <input type="checkbox"/> Category 2 <input type="checkbox"/> Category 3 <input type="checkbox"/> Category 4 <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Obstetrics & Gynaecology <input type="checkbox"/> Gynaecology General <input type="checkbox"/> Obstetrics <input type="checkbox"/> Gynaecological Oncology <input type="checkbox"/> Uro-gynaecology <input type="checkbox"/> Ultrasound <input type="checkbox"/> Advanced Endoscopic Surgery <input type="checkbox"/> Laparoscopic Surgery <input type="checkbox"/> Maternal Fetal Medicine <input type="checkbox"/> Occupational Medicine <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Oral & Maxillofacial Services <input type="checkbox"/> Facio Maxillary Surgery <input type="checkbox"/> Orthopaedics <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Paediatric Medicine <input type="checkbox"/> General Medicine <input type="checkbox"/> Oncology/Haematology <input type="checkbox"/> Neurology <input type="checkbox"/> Nephrology <input type="checkbox"/> Respiratory <input type="checkbox"/> Rheumatology <input type="checkbox"/> Cardiology <input type="checkbox"/> Other _____	<input type="checkbox"/> Paediatric Surgery <input type="checkbox"/> Neonatal <input type="checkbox"/> Palliative Care <input type="checkbox"/> Pathology <input type="checkbox"/> Anatomical <input type="checkbox"/> Biochemistry <input type="checkbox"/> Laboratory Haematology <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Microbiology <input type="checkbox"/> Physicians/Internal Medicine <input type="checkbox"/> Clinical Haematology <input type="checkbox"/> General Medicine <input type="checkbox"/> Geriatrics <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Neurology <input type="checkbox"/> Nephrology <input type="checkbox"/> Respiratory <input type="checkbox"/> Rheumatology <input type="checkbox"/> Other _____ <input type="checkbox"/> Plastic & Reconstructive Surgery <input type="checkbox"/> Adults <input type="checkbox"/> Paediatric <input type="checkbox"/> Psychiatry <input type="checkbox"/> Sub Specialty specify: _____ <input type="checkbox"/> ECT <input type="checkbox"/> CYMH <input type="checkbox"/> Medical Imaging <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Rehabilitation Medicine <input type="checkbox"/> Urology <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Vascular Surgery <input type="checkbox"/> Endovascular Procedures <input type="checkbox"/> Thoracic Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric		
OTHER CLINICAL PRACTICE SOUGHT (Not applicable to Surgical Assistants)				
FIELD	Surgical Admitting	Medical Admitting	Consulting	Other (Specify)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CLINICAL PRACTICE SOUGHT AS THE FOLLOWING SPECIALIST(S) IN THE CARDIOVASCULAR UNIT** (Please tick)

- |  |   |
|--|---|
| <input type="checkbox"/> Cardiologist                | <input type="checkbox"/> Interventional Radiologist |
| <input type="checkbox"/> Interventional Cardiologist | <input type="checkbox"/> Vascular Surgeon           |
| <input type="checkbox"/> Electrophysiologist         |   |

**DETAIL THE AREAS OF CLINICAL PRACTICE REQUESTED:** (Please tick)

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Cardiology</b>              | <input type="checkbox"/> <b>Endovascular Procedures</b> |
| <input type="checkbox"/> Diagnostic Procedures          | <input type="checkbox"/> Diagnostic Procedures          |
| <input type="checkbox"/> Interventional Procedures      | <input type="checkbox"/> Peripheral Interventions       |
| <input type="checkbox"/> EP Procedures                  | <input type="checkbox"/> Carotid Interventions          |
| <input type="checkbox"/> Implantable Electronic Devices | <input type="checkbox"/> AAA Stent Grafts               |
| <input type="checkbox"/> Paediatric Procedures          | <input type="checkbox"/> Embolization Procedures        |

**COMPETENCY GUIDELINES:** (Please tick)**Cardiology**

**During Training or within the last 5 years of clinical practice** (did you meet or exceed these amounts – if not what quantity?)

**Current Practice** - across all institutions you visit (do you meet or exceed these amounts – if not what quantity?)

- |   |  |  |
|---|--|--|
| Diagnostic Procedures   | <input type="checkbox"/> participate in 400 Coronary Angiograms<br><input type="checkbox"/> perform 150 cases as supervised operator<br><input type="checkbox"/> perform 150 cases as primary operator   | <input type="checkbox"/> 100 cases / year  |
| Interventional Procedures   | <input type="checkbox"/> participate in 400 cases (100 complex)<br><input type="checkbox"/> perform 200 cases as primary operator  | <input type="checkbox"/> 75 cases / year   |
| Electrophysiology Studies   | <input type="checkbox"/> participate in 150 diagnostic cases<br><input type="checkbox"/> participate in 100 ablation cases<br><input type="checkbox"/> perform 50 cases as primary operator<br><input type="checkbox"/> perform 10 trans-septal catheterizations | <input type="checkbox"/> 40 cases / year (30 as ablations)   |
| Implantable Electronic Devices<br>(pacemakers and ICD's – single, dual & Bi-V, active & passive fixation) | <input type="checkbox"/> perform 75 implants<br><input type="checkbox"/> perform 20 revisions<br><input type="checkbox"/> perform 15 Bi-Ventricular implants   | <input type="checkbox"/> 12 pm & 10 ICD implants / year<br><input type="checkbox"/> 5 revisions / year<br><input type="checkbox"/> follow 50 PM & 20 ICD patients / year |
| Cardiac Interventions (valvuloplasty, PFO/ASD Closures etc)   |  | <input type="checkbox"/> 5 cases / year  |

**Endovascular**

- |                            |  |  |
|----------------------------|--|--|
| Peripheral Angiography     | <input type="checkbox"/> perform 100 cases (50 as primary operator)  | <input type="checkbox"/> 20 cases / year |
| Peripheral Interventions   | <input type="checkbox"/> perform 50 cases (25 as primary operator)   | <input type="checkbox"/> 20 cases / year |
| Carotid Interventions      | <input type="checkbox"/> perform 100 peripheral angiograms (not only carotids)<br><input type="checkbox"/> perform 15 cases (10 as primary operator) | <input type="checkbox"/> 10 cases / year |
| AAA Stent grafts           | <input type="checkbox"/> perform 10 cases (5 as primary operator)  | <input type="checkbox"/> 5 cases / year  |
| Cerebral Embolizations     | <input type="checkbox"/> perform 100 cervicocerebral angiograms<br><input type="checkbox"/> perform 20 cerebral embolizations                        | <input type="checkbox"/> 5 cases / year  |
| Ovarian Vein Embolizations | <input type="checkbox"/> perform 50 cases (25 as primary operator)   | <input type="checkbox"/> 10 cases / year |

**CVU AUDIT GUIDELINES:** (Please tick)

- I will participate in regular case / image review audits
- I will participate in regular mortality / morbidity data audits
- I will participate in regular procedural outcome and complication data audits
- I will participate in regular radiation safety audit and review

**REFEREES**

For each major specialty in which you are seeking clinical practice, please provide names, addresses, telephone numbers, facsimile numbers and email addresses of three (3) professional referees (at least one from your own profession) who can attest to your recent practice and have known you for at least 12 months within the past 3 years. We prefer (where possible) that these referees are independent. However, where there is a relationship which may lead to a bias, such as a referee and the applicant are in business together as a partnership, or are employer/employee, then this relationship must be disclosed by you to the hospital. Please note that your referees will be contacted and asked to provide a reference. The reference should be in writing.

<b>Specialty</b>			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

<b>Specialty</b>			
(Referee 1) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 2) Name			
Address			
Phone		Facsimile	
Email Address			
(Referee 3) Name			
Address			
Phone		Facsimile	
Email Address			

**PRIMARY UNDERGRADUATE QUALIFICATION** (List below or attach CV)

Name of University/ Institution	Degree/s	Graduation Year

**POSTGRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS, COLLEGE OR PROFESSIONAL QUALIFICATIONS** (List below or attach CV – copies of qualification/s to also be attached)

Qualification	Date Obtained	Accredited Training Organisation





## DECLARATION AND AUTHORITY

I authorise ST ANDREW'S TOOWOOMBA HOSPITAL, its employees, officers and the Medical Advisory Committee, to obtain information on an annual, or as necessary, basis from the registration body/indemnity insurance organisation as nominated in this application, regarding the currency of my registration/membership of that body/organisation.

### Specialist Directory

I authorise ST ANDREW'S TOOWOOMBA HOSPITAL to include my practice details in any Hospital Specialist Directory. Yes  No

I authorise ST ANDREW'S TOOWOOMBA HOSPITAL to conduct a criminal record check in respect of my history including information relevant to the provision of services to children and I agree to notify the Chief Executive Officer if I am convicted of a sex or violence offence or any other offence relevant to my practice as a Medical Practitioner.

I authorise ST ANDREW'S TOOWOOMBA HOSPITAL, its officers and the Medical Advisory Committee to verify with relevant individuals, external organisations, and nominated referees the validity of all claims made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history, claims and legal proceedings.

I declare that I have no physical or mental condition or substance abuse problem that could affect my ability to exercise the scope of clinical practice requested or that would require any special assistance in order to enable me to exercise that scope of clinical practice safely and competently. I undertake to notify ST ANDREW'S TOOWOOMBA HOSPITAL if this statement becomes incorrect in the future.

I declare that my medical indemnity/professional indemnity cover is adequate and appropriate for the Clinical Privileges and activity which is the subject of this application.

I declare that I am the person named in this application and that the information provided by me in this application and in connection with this application is accurate and complete 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 St Andrew's Toowoomba Hospital Board may (in its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.

In applying for appointment I acknowledge that I have been provided with, and read, a copy of the Hospital By-Laws and if appointed, agree to abide by the By-Laws and policies of the ST ANDREW'S TOOWOOMBA HOSPITAL, including any annexure or variation to the By-Laws during the tenure of my appointment, all relevant legislative requirements (including compliance with HQCC Standards) and any terms and conditions which are attached to my appointment by the Board/Licensee.

I undertake to notify the ST ANDREW'S TOOWOOMBA HOSPITAL promptly and in writing, if my scope of clinical practice is altered at any other hospital or day procedure centre.

I agree to attend committee and clinical meetings at the facility to support my discipline within the facility, and to participate in any clinical quality assurance activity including submitting my practice to clinical audit and peer review, in conjunction with the hospital, the Medical Advisory Committee or clinical speciality committees if required by ST ANDREW'S TOOWOOMBA HOSPITAL.

I undertake to notify ST ANDREW'S TOOWOOMBA HOSPITAL should any information provided in this application for appointment vary in any way

I acknowledge and agree to release ST ANDREW'S TOOWOOMBA HOSPITAL from and against all claims out of a decision to suspend or terminate my accreditation or to not re-appoint me in circumstances set out in the Hospital By-Laws.

In the event of myself or the aforementioned practitioner(s) being unavailable in the case of an emergency, I am agreeable to the facility seeking urgent alternative assistance with authority to be exercised only after consultation with the facility Chief Executive Officer or duly authorised person.

I understand that my Appointment will be reviewed in three (3) years or earlier if considered necessary.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

WITNESS NAME \_\_\_\_\_ WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

### NOTE: COPIES OF THE FOLLOWING MUST ACCOMPANY THIS APPLICATION:

- CURRICULUM VITAE
- EVIDENCE OF QUALIFICATIONS & PARTICIPATION IN CONTINUING MEDICAL EDUCATION
- PROOF OF REGISTRATION
- PROFESSIONAL INDEMNITY – CERTIFICATE OF CURRENCY

**CONSIDERATION OF ACCREDITED PRACTITIONER APPLICATION FOR APPOINTMENT FORM**

**OFFICE USE ONLY**

**PRACTITIONER NAME:** \_\_\_\_\_

**PROVIDER NUMBER** \_\_\_\_\_

		<b>PRIVILEGES GRANTED</b>	<b>DATE</b>
Application Form Completed & CV received Y <input type="checkbox"/> N <input type="checkbox"/>	Date:		
Copy of Registration Received Y <input type="checkbox"/> N <input type="checkbox"/>	Date:	Approved by Licensee as evidenced by the letter sent on behalf of the Licensee, confirming the appointment	
Copy of certificate of currency for Medical Indemnity Insurance received. Y <input type="checkbox"/> N <input type="checkbox"/>	Date:	Applicant Notified	
Copy of Post Graduate Qualifications and Copy of College Fellowship Received Y <input type="checkbox"/> N <input type="checkbox"/>	Date:	Application entered into Hospital IT Management System	
Copy of certificate showing participation in Continuing Medical Education (where available) Y <input type="checkbox"/> N <input type="checkbox"/>	Date:	Registration/Insurance Renewal Dates noted	
Relevant References Received Y <input type="checkbox"/> N <input type="checkbox"/>  References Reviewed Y <input type="checkbox"/> N <input type="checkbox"/>	Date:  Date:  Name of Reviewer:	Date for re-application	
Recommended by Credentialling Committee	<b>Name of Peer Reviewer:</b>  Date:  Signature:	Date of withdrawal from list	
Recommended by Medical Advisory Committee	Date:  Signature:		
Recommended by Chief Executive Officer	Date:  Signature:		

*Note: To ensure facilities fully comply with the requirement to document the credentialing process, it is recommended that a photocopy of this page be circulated with the agenda and a copy attached to the minutes of the Credentialling Committee meeting at which the application is approved. The completed original of this form should remain with the complete application.*