THE SYDNEY PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

63 Victoria Street,
Ashfield NSW 2131
Tel: (02) 9797 0555
Fax: (02) 9798 8561

APPLICATION FOR VISITING PRACTITIONER (VP) RIGHTS

1. **SURNAME:** _____ **GIVEN NAME/S:** _____

2. **DATE OF BIRTH:** _____

3. **PROVIDER NO.:** _____ **PRESCRIBER NO:** _____

4. **ADDRESS:**

PROFESSIONAL: _____

_____

TELEPHONE: _____FAX: _____

MOBILE: _____

POSTAL: _____

EMAIL: _____

5. **CLINICAL SCOPE OF PRACTICE APPLIED FOR:**

_____

List of operations you expect to perform:

_____

_____

_____

_____

_____

6. **QUALIFICATIONS:**

_____

_____

7. **DETAILS OF REGISTRATION:**

Initial Date of Registration in NSW ___ / ____ / ____ Registration No._____

(Please supply copy)

8. **WORKING WITH CHILDREN CLEARANCE CHECK**

Apply for your working with children check at
https://wwccheck.ocg.nsw.gov.au/Applicants/Application

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9. MEDICAL INDEMNITY INSURANCE: (Please supply copy)

Provider: _____
DATES OF COVERAGE: _____

9.1 Have there ever been or are there currently pending any claims, settlements or judgements against you? Yes / No

9.2 Has your medical defence organisation ever excluded any specific area of practice, or terminated or denied coverage? Yes / No

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.

10. DISCIPLINARY ACTIONS:

10.1 Are you currently restricted by AHPRA? Yes / no

10.2 Have you ever been convicted of any criminal charges (other than motor vehicle offences)? Yes / no

10.3 Have you ever been convicted of a drug or alcohol related offence? Yes / no

10.4 Has your accreditation ever been revoked from another hospital?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.

11. REFEREES: (please list the names of TWO (2) Medical Practitioners who will attest to this application. Referee's must be in your specialty group.)

Surgical Assistants will only require one reference.

Name _____Position: _____

Email: _____Phone: _____

Name _____Position: _____

Email: _____Phone: _____

12. Copy of accredited laser certificate YES/ NO/ N/A

13. Copy of accredited radiation certificate YES/ NO/ N/A

14. Copy of GESA recertification certificate YES/ NO/ N/A

15. 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.

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A copy of the by-laws, rules and regulations will be supplied with this application.

I accept and agree to abide by the current by-laws policies and all revisions issued as necessary by The Sydney Private Hospital – Ashfield.

16. SIGNATURE OF APPLICANT: _____

Date: _____

18. HOSPITAL USE ONLY:

18.1 References Checked: ___

18.2 Registration checked: ___

18.3 Insurance checked: ___

18.4 Working with Children Checked: _____ **WWCC Number** _____

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

18.6 Radiation Licence provided (if applicable): ___

18.7 GESA Recertification Certificate (if applicable) ___

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

18.9 18.9.1 Submitted to Medical Advisory Chairman: _____
(print name)

18.9.2 Submitted to Medical Advisory Chairman: _____
(signature)

18.9.3 Submitted to Medical Advisory Chairman: _____
(date)

18.10 Applicant notified: _

18.11 * Conditions noted** ___ Yes ___ NO

***** Conditions sighted by Chairman** ___ Yes ___ NO

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