THE SYDNEY PRIVATE HOSPITAL

ABN: 97 094 662 914

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

APPLICATION FOR VISITING PRACTITIONER (VP) RIGHTS

1. SPECIALTY -APPLYING FOR:_____

1.1 PLEASE PROVIDE A LIST OF PROCEDURES YOU INTEND TO PERFORM. **(*ON A SEPARATE SHEET OF PAPER*)**

2. QUALIFICATIONS:

_____

_____

3. DATE OF APPLICATION: _____

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

5. PRESCRIBER NO:_____ **PROVIDER NO.:**_____

6. PRESENT HOSPITAL APPOINTMENTS

Public: _____

Other Hospitals to which you admit patients _____

7. ADDRESS:

7.1 PROFESSIONAL:_____

_____

POSTAL:_____

TELEPHONE:_____FAX:_____

MOBILE:_____ PAGER:_____

EMAIL:_____

7.2 RESIDENTIAL: _____

_____TELEPHONE:_____

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

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

8.2 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.

9. DISCIPLINARY ACTIONS:

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

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

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

9.4 HAS YOUR ACCREDITATION EVER BEEN REVOKED FROM ANOTHER HOSPITAL? ☐ Y / N ☐

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. DETAILS OF REGISTRATION:

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

11. WORKING WITH CHILDREN CLEARANCE CHECK?

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

12. REFEREES: (please list the names of TWO (2) Medical Practitioners who will attest to this application. 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:_____

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

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

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

16. 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.

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

18. SIGNATURE OF APPLICANT:_____

18. HOSPITAL USE ONLY:

18.1 **References Checked:** ___

18.2 **Registration checked:** ___

18.3 **Insurance checked:** ___

18.4 **Working with Children Checked:** ___

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:** ___

HOSPITAL / ADMIN USE ONLY:

18.10 **WWCC verified on line check**

Date	WWCC Number	Birth date	Expiry date

18.11 *** **Conditions noted** ___ Yes ___ NO

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