THE SYDNEY PRIVATE HOSPITAL

ABN: 14 064 223 481 002

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

RE- APPLICATION FOR VISITING PRACTITIONER RIGHTS

1. SPECIALTY APPLIED FOR:_____

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

2. QUALIFICATIONS:

_____

_____

3. 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 SUCH BY-LAWS, RULES AND REGULATIONS WILL BE SUPPLIED WITH THIS APPLICATION.

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

5. DATE OF BIRTH:_____

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

7. ADDRESS:

7.1 PROFESSIONAL:_____

_____

TELEPHONE:_____FAX:_____

MOBILE:_____ PAGER:_____

OSTAL:_____

EMAIL:_____

7.2 RESIDENTIAL: _____

_____TELEPHONE:_____

8. DETAILS OF REGISTRATION: (Registration means, in the case of a Medical Practitioner, Registration under the NSW Medical Practitioner Act No. 37, 1938, as amended.
Where an applicant is other than a Medical Practitioner it means such Registration as may be required either by statue or the various authorities in the State.)

8.1 DATE ISSUED:_____ REG. NO:_____

TYPE:_____ DATE EXPIRES:_____ (Please supply copy)

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

9.1 HAVE THERE EVER BEEN OR ARE THERE CURRENTLY PENDING ANY CLAIMS, SETTLEMENTS OR JUDGEMENTS AGAINST YOU? ☐ / ☐

9.2 HAS YOUR MEDICAL DEFENCE ORGANISATION EVER EXCLUDED ANY SPECIFIC AREA OF PRACTICE, OR TERMINATED OR DENIED COVERAGE? ☐ / ☐

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.

****PLEASE PROVIDE A COPY OF YOUR REGISTRATION ,INSURANCE and WORKING WITH CHILDREN CHECKS****

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)

10. HOSPITAL APPOINTMENTS (please list dates)

CURRENT:_____

_____

If this space is insufficient, please attach a separate piece of paper.

11. CONTINUING EDUCATION (please list any Educational achievements since completing your last Application for Visiting Rights.)

_____

_____

I ACCEPT AND AGREE TO ABIDE BY THE BY-LAWS AND POLICIES OF THE SYDNEY PRIVATE HOSPITAL – ASHFIELD.

SIGNATURE OF APPLICANT: _____ **DATE OF APPLICATION:** _____

HOSPITAL USE ONLY:

Registration checked:_____

Insurance checked: _____

Working with Children Check: _____

Approved by Section Head:_____ **Date:**_____

Submitted to Medical Advisory Committee:_____

Submitted to Board:_____

Applicant notified: _____