THE SYDNEY PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

63 Victoria Street, ASHFIELD NSW 2131
ABN 97 094 662 914
Tel (02) 9797 0555 Fax (02) 9798 8561

CREDENTIALING APPLICATION FOR VISITING PRACTITIONER (VP) RIGHTS

1. SPECIALTY APPLYING FOR:_____

1.1 PLEASE PROVIDE A LIST OF PROCEDURES plus your scope of practice YOU INTEND TO PERFORM. (***ADDITIONAL SHEETS OF PAPER CAN BE ATTACHED, IF REQUIRED).***

_____

_____

2. QUALIFICATIONS:

_____

_____

3. DATE OF APPLICATION: _____

4. FULL NAME:_____ 5. **DATE OF BIRTH:**_____

6. PRESCRIBER NO:_____ **7. PROVIDER NO.:**_____

8. PRESENT HOSPITAL APPOINTMENTS

Public: _____

Other Hospitals to which you admit patients _____

9. ADDRESS:

9.1 PROFESSIONAL:_____

_____

POSTAL:_____

TELEPHONE:_____FAX:_____

MOBILE:_____

EMAIL:_____

9.2 RESIDENTIAL: _____

_____TELEPHONE:_____

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

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

10.2 HAS YOUR MEDICAL DEFENCE ORGANISATION EVER EXCLUDED ANY SPECIFIC AREA OF PRACTICE, OR TERMINATED OR DENIED COVERAGE? **YES / NO**

11. DISCIPLINARY ACTIONS:

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

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

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

11.4 HAS YOUR ACCREDITATION EVER BEEN REVOKED FROM ANOTHER HOSPITAL?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.

12. DETAILS OF AHPRA REGISTRATION:

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

13. PROOF OF ID:

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

13.2 Photo ID ☐ **13.2 Police Check** ☐

14. REFEREES: (Please attach references from (2) Medical Practitioners. Both letters must be on letterhead and 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:_____

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

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

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

18. 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.

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

20. SIGNATURE OF APPLICANT: _____ Date: _____

21. HOSPITAL USE ONLY:

21.1 References Checked: ___
If reference emailed, send email to the referee verifying that the reference was sent from them.

21.2 Registration checked: ___

21.3 Insurance checked: ___

21.4 Working with Children Checked: ___

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

21.6 Radiation Licence provided (if applicable): ___

21.7 GESA Recertification Certificate (if applicable) ___

21.8 Approved by Hospital Director: _____ Date: __ __ / __ __ / _____

21.9 21.9.1 Submitted & approved to Medical Advisory Chairman:

_____
(print name)

21.9.2 Submitted & approved to Medical Advisory Chairman:

_____
(signature)

21.9.3 Submitted & approved to Medical Advisory Chairman:

_____
(date)

21.10 21.10.1 Submitted & approved to MAC Committee member:

_____
(print name)

21.10.2 Submitted & approved to MAC Committee member:

_____
(signature)

21.10.3 Submitted & approved to MAC Committee member:

_____
(date)

21.11 Applicant notified: ____

21.12 WWCC verified online check.

Date	WWCC Number	Birth date	Expiry date

21.13 CONDITIONS

21.13.1	**Conditions noted.**	**YES**	**NO**	
21.13.2	**Conditions sighted by MAC Chairman.**	**YES**	**NO**	
21.13.3	**Conditions approved by corporate Executive of MHC for final approval.**	**YES**	**NO**	