Credentialing and Scope of Clinical Practice Application Form

Little Company of Mary Health Care Limited

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1 Application for Accreditation

I hereby apply to Little Company of Mary Health Care Ltd (Calvary) for Accreditation to practise at and/or provide services to patients of the

..... (Calvary Service)

within a designated Scope of Clinical Practice.

I wish to also be Accredited at the following Calvary Services (if applicable).

I am applying for:

☐ Re-Accreditation

☐ Initial Accreditation (I am not currently Accredited)

☐ *For applicants for initial accreditation only* - I would also like to be considered for temporary accreditation while my application for initial Accreditation is being processed

☐ Accreditation as a Locum Tenens (please provide details of the practitioner for whom you will be providing locum tenens services and the requested period of accreditation):

_____

☐ I wish to be authorised to admit patients to the Calvary Service(s) identified above

OR

☐ I wish to be authorised only to consult on the patients admitted under the care of other health care practitioners

To support my application I submit the following information (**please print** and attach separate sheets if insufficient space).

AUTHORISATION TO PRACTISE SOUGHT IN THE FOLLOWING CATEGORY (please tick)

(Please see *conditions associated with Accreditation Categories* at **Attachment 1**).

- ☐ Specialist Practitioner
- ☐ General Practitioner
- ☐ General Practitioner (Obstetrics)
- ☐ General Practitioner (Anaesthetics)
- ☐ Staff Specialist
- ☐ Hospital Medical Practitioner
- ☐ Surgical Assistant
- ☐ Consultant Emeritus
- ☐ Dentist
- ☐ Allied Health Practitioner
- ☐ Midwife
- ☐ Midwife Practitioner
- ☐ Nurse
- ☐ Nurse Practitioner

DETAIL OF SCOPE OF CLINICAL PRACTICE REQUESTED - Medical and Dental Practitioners (Surgical Assistants are not required to complete this section)

General Practice
- ☐ Anaesthetics 3 yrs and over
- ☐ Obstetrics uncomplicated deliveries
- ☐ Obstetrics instrument deliveries (excluding Kielland Forceps)
- ☐ Caesarean section
- ☐ Obstetrics other (please provide details

.....

- ☐ Non-procedural GP
- ☐ Other (please provide details)

.....

Specialist anaesthesia
- ☐ Adults
- ☐ Neonatal (<4 weeks)
- ☐ Obstetric
- ☐ Paediatric (>4 weeks)

Cardiology
- ☐ General
- ☐ Procedural*

Cardiothoracic Surgery*
- ☐ Adult
- ☐ Paediatric

Dental
- ☐ Adult
- ☐ Paediatric

Dermatology
- ☐ Adult
- ☐ Paediatric

Emergency Medicine
- ☐ Adult
- ☐ Paediatric

Endocrinology
- ☐ Adult
- ☐ Paediatric

ENT Surgery
- ☐ Adult
- ☐ Paediatric
- ☐ Paediatric Endoscopic*
- ☐ Head and Neck*

Gastroenterology
- ☐ Endoscopy
- ☐ Routine
- ☐ Emergency Upper GIT bleed
- ☐ ERCP
- ☐ Colonoscopy

General Surgery
- ☐ Adult
- ☐ Paediatric
- ☐ Endoscopy*
- ☐ Laparoscopic Surgery*

Intensive Care
- ☐ Adult
- ☐ Paediatric
- ☐ Neonatal

Internal Medicine
- ☐ General Medicine
- ☐ Geriatrics
- ☐ Neurology
- ☐ Nephrology
- ☐ Respiratory
- ☐ Rheumatology
- ☐ Other.....

☐ Medical Administration

Medical Imaging
- ☐ Adult
- ☐ Paediatric
- ☐ Radiation Oncology
- ☐ Procedural*

Neonatology
- ☐ Category 1
- ☐ Category 2
- ☐ Category 3
- ☐ Category 4

Neurosurgery
- ☐ Adult
- ☐ Paediatric

☐ Nuclear Medicine

Obstetrics and Gynaecology
- ☐ Gynaecology general
- ☐ Obstetrics
- ☐ Gynaecology oncology
- ☐ Uro-gynaecology
- ☐ Ultrasound
- ☐ Colposcopy
- ☐ Adv. Endoscopic Surgery*
- ☐ Laparoscopic Surgery*
- ☐ Maternal Fetal Medicine
- ☐ Assisted Reproductive Medicine (IVF)

☐ Occupational Medicine

Oncology (Adult)
- ☐ Medical Oncology

Ophthalmology
- ☐ Adult
- ☐ Paediatric

Oral and Maxillofacial Surgery
- ☐ Facio Maxillary Surgery

Orthopaedics
- ☐ Adult
- ☐ Paediatric

Paediatric medicine
- ☐ General Medicine
- ☐ Oncology/haematology
- ☐ Neurology
- ☐ Nephrology
- ☐ Respiratory
- ☐ Rheumatology
- ☐ Cardiology
- ☐ Other

Paediatric Surgery
- ☐ Neonatal
- ☐ General

☐ Palliative Care

Pathology
- ☐ Anatomical
- ☐ Biochemistry
- ☐ Clinical haematology
- ☐ Infectious diseases
- ☐ Microbiology

Plastic and Reconstructive Surgery
- ☐ Adult
- ☐ Paediatric

Psychiatry
- ☐ Specify Sub Specialty

.....

- ☐ ECT
- ☐ CYMH

☐ Public Health

☐ Rehabilitation Medicine

☐ Transplant Surgery*

☐ Specify Sub Specialty

.....

Urology
- ☐ Adult
- ☐ Paediatric

☐ Vascular Surgery

Other – please specify

.....

*on a separate document specify level of procedures and attach evidence of competency

DETAIL OF SCOPE OF CLINICAL PRACTICE REQUESTED - Allied Health Practitioners, Midwives, Midwife Practitioners, Nurses and Nurse Practitioners

Please describe the scope of clinical practice in which you wish to engage, including any areas of clinical specialisation and any procedures (invasive or non-invasive) associated with your practice.

2 Personal and practice details

Title (e.g. Dr, Mr, A/Prof, Prof)			
Surname			
Given name(s)			
Any former names (including maiden name)		**Prescriber No**	
		Provider No	
Name of partner/spouse (optional, for invitation list only)			

Residential address			
	Postcode		
Telephone		**Pager no**	
Facsimile		**Mobile No**	

Practice address			
	Postcode		
Telephone		**Facsimile**	
Email			

Postal address	
	Postcode

3 Qualifications

(Please **attach certified copies** of original certificates)

Degree/fellowship	Conferring body	Year

Do you consent to Calvary contacting the conferring bodies nominated above to request verification of your qualifications?

☐ Yes ☐ No

If you answered no to the above, please specify which conferring bodies may not be contacted. Note that when assessing your application Calvary will take into account the extent to which it is able to verify your qualifications.

4 Details of membership of professional associations

5 Current appointments

Please list all senior appointments* held at public and private hospitals/health services

Hospital/health service	Appointment	Duration (years)

*A senior appointment is one in which you were authorised to admit and/or treat patients without the direct supervision of another senior clinician. It does not include appointments in which you were not authorised to admit and/or treat patients independently, such as appointments as a hospital medical officer or registrar.

6 Past appointments

Please list all previous senior appointments held at public and private hospitals/health services

Hospital/health service	Appointment	Year commenced	Year completed

7 Consent to verify performance at other health services

Do you consent to Calvary contacting the Chief Executive Officer, Director of Medical Services, Director of Clinical Services or their senior delegate of the hospitals/health services listed in which you have held current and past appointments to request verification of the adequacy of your performance in the areas of clinical care, leadership, communication and professionalism?

☐ Yes ☐ No

If you answered no to the above, please specify which health services or individuals may not be contacted. Note that when assessing your application Calvary will take into account the extent to which it is able to obtain information about your performance at other health services.

8 Registration

Please supply details of your current registration with a national health practitioner registration board and **attach a copy** of your current registration certificate

_____**Board of Australia**

Registration number_____

Specialty (if applicable)_____

9 Certification/licence for the use of radiographic equipment

If you have applied for a Scope of Clinical Practice which includes the use of radiographic equipment, do you hold the necessary certification/licence as required by the law in your state to operate such equipment?

☐ Yes ☐ No ☐ Not applicable

Please **attach a copy** of your current certificate/licence

10 Insurance

Does your professional indemnity insurance policy cover your proposed Scope of Clinical Practice at Calvary as detailed in this application?

☐ Yes ☐ No

If you answered no to the above, please provide details

Please **attach a copy** of your current professional indemnity insurance policy/schedule

11 References

Please provide names and contact details below of three peer referees who have had close professional contact with you in the past twelve months and can comment on your professional competence and performance. Your referees will be contacted directly and asked to provide a written reference addressing a range of criteria including clinical expertise, leadership, communication and professionalism. We prefer (where possible) that these referees are independent. However, where there is a business or personal relationship which could reasonably be perceived to lead to bias (e.g. you are in business together) you must disclose this relationship in this application.

Name of referee	**Address**	**Phone and email contact details**

Please specify the nature of any relationship with a nominated referee that could reasonably be perceived to lead to bias

12 Nominated alternative practitioner in event of emergency

I acknowledge that it is my responsibility to arrange appropriate clinical cover for my patients at all times.

In the event that I am unable to be contacted for a clinical emergency, the person nominated below is an appropriately qualified practitioner accredited at the Service who has agreed to deputise for me

Name_____

Contact telephone number_____

13 Disclosure

Has your **Scope of Clinical Practice** ever been limited, restricted or withdrawn at any health service on either a temporary or permanent basis (please tick “yes” or “no” below)?

☐ Yes ☐ No

If you answered yes to the above, please provide details (including details of the type of limitation, restriction or withdrawal and the time period for which it applied)

Has your **registration with any practitioner registration board** (Australia or overseas) ever been restricted, limited, suspended or terminated (please tick “yes” or “no” below)?

☐ Yes ☐ No

If you answered yes to the above, please provide details, (including details of the type of restriction, limitation, suspension or termination and the time period for which it applied)

Has your **professional indemnity insurance** ever been restricted, limited, suspended or terminated (please tick “yes” or “no” below)?

☐ Yes ☐ No

If you answered yes to the above, please provide details, (including details of the type of restriction, limitation, suspension or termination and the time period for which it applied)

Do you **suffer from any health impairment or use any substances (licit or illicit)** which may limit your ability to exercise the scope of clinical practice which you have requested?

☐ Yes ☐ No

If you answered yes to the above, please provide details.

Has there ever been any **serious adverse finding** made against you which would be relevant to this application for Accreditation (for example, breach or insurance, breach of laws governing health care, professional misconduct, sexual assault) by the Health Insurance Commission, Medicare Australia, a practitioner regulation board a health care complaints commission or equivalent body, a coroner, a court or any professional disciplinary or similar body (please tick "yes" or "no" below)?

☐ Yes ☐ No

If you answered yes to the above, please provide details (including details of the adverse finding)

Have you been **convicted of or pleaded guilty to a criminal offence** including a serious sexual or violent offence or an offence involving dishonesty or drugs (other than a spent conviction)?

☐ Yes ☐ No

If yes, please provide details

Working with children

A Working with Children Check (or similar, as relevant in the jurisdiction in which you are applying for Accreditation) is required of applicants who will be undertaking direct and unsupervised contact with children in the course of their work.

Are you likely to be undertaking work which would meet the definition above of working with children?

☐ Yes ☐ No

If you answered yes to the above question, do you consent to making the declarations required by law in relation to working with children and to Calvary making the relevant Working With Children Check required by the law?

☐ Yes ☐ No

14 Declaration

I declare that:

- The information that I have provided in this application is complete, true and correct in every particular. I understand that if I have provided misleading or deceptive information or information which is likely to mislead or deceive, the Board of Calvary may (in its absolute discretion) conclude that I do not have "Current Fitness" under the Service By-laws and terminate my .accreditation in accordance with the Service By-Laws.
- I have read, accept and agree to observe each and all of the Service By-Laws (as may be amended or replaced from time to time) and to comply with the Service By-Laws, policies and procedures as they apply from time to time for the duration of my accreditation.
- I will observe:
    - the Code of Ethical Standards for Catholic Health and Aged Care and the policies and codes of conduct or codes of behaviour adopted by Little Company of Mary Health Care and/or the Service from time to time;
    - generally accepted ethics of professional practice, including in relation to colleagues and patients under my care;
    - all legislative requirements.
- I will not make use of or (except as required by law or any competent regulatory body) disclose or divulge to any third party any information of a secret or confidential nature relating to the business or affairs of the Service and/or Little Company of Mary Health Care.
- I will notify the Chief Executive Officer of the Service of any material changes to the information provided by me in connection with this application as soon as practicable after the change.

I unconditionally and irrevocably agree to release the Service from and against all losses, expenses, costs and claims that I may suffer or incur arising directly or indirectly out of a decision to vary or suspend my Scope of Clinical Practice or vary, suspend or terminate my Accreditation as provided for in the Service By-laws.

I understand that my Accreditation, if granted, will be reviewed in 5 years or earlier if considered necessary.

Signature:_____ Date:_____

Witness name:_____

Signature:_____ Date:_____

Please attach copies of the following documents:

- full curriculum vitae
- copies of original qualification certificates
- copy of College Fellowship (if applicable)
- copy of professional indemnity insurance policy/schedule
- copy of current certificate/licence to operate radiographic equipment
- copy of current certificate/licence to operate laser equipment
- copy of current registration certificate.

15 Consideration of application for Accreditation

For internal use only

1 Application for initial appointment not accepted by Chief Executive Officer

Signature_____Date_____
(Chief Executive Officer of authorised delegate)

Notify applicant, no further action required

2 If application accepted:

- ☐ Credentials including original qualification, fellowship certificates and other relevant qualifications sighted, copied and attached to the practitioner's personnel file and references reviewed and verified in accordance with Calvary policy
- ☐ References checked and recorded in accordance with Calvary policy
- ☐ Health practitioner registration verified directly with relevant board
- ☐ Professional indemnity insurance certificate sighted and verified with a copy placed in the health practitioner's personnel file
- ☐ Level of indemnity verified by the practitioner's insurer as appropriate for the scope of clinical practice requested
- ☐ Disclosure section completed in full and any relevant issues investigated and findings documented in the practitioner's personnel file
- ☐ Nomination of alternative in case of an emergency including correct current contact details verified
- ☐ Declaration signed and dated

Verified by_____Date_____
(Chief Executive Officer or authorised delegate)

Please retain copies of credentials and references in Practitioner's personnel file

3 Review of application

For applications for temporary accreditation only, consultation with senior clinical advisers as required by the By-Laws (please record who was consulted and comments)

Person who undertook consultation_____
(Chief Executive Officer or authorised delegate)

Date_____

For all other applications, recommendations of Medical Advisory Committee

Date of meeting_____

Recommendations

- Accreditation category_____
- Scope of clinical practice_____
- Period of accreditation_____
- Special conditions of accreditation (if any)

4 Recommendation of Chief Executive Officer to Board

As per Medical Advisory Committee recommendation: Yes/No

If no, Chief Executive Officer recommendation:

5 Board decision (including period and conditions of Accreditation)

As per Chief Executive Officer recommendation: Yes/No

If no, Board decision:

Please attach letter of advice to applicant, confirming decision of Board

Attachment 1 - Conditions associated with Accreditation

Specialist Practitioners, Staff Specialists and Dentists:

(a) may admit and treat patients within their authorised Scope of Clinical Practice;

(b) must assume responsibility for the clinical care of patients admitted under their care;

(c) must participate in continuing education activities of the Service; and

(d) are full members of the Medical Association.

Surgical Assistants:

(a) may not admit patients but may assist in theatre and visit patients in ward areas and examine clinical records;

(b) may not initiate or change treatment orders;

(c) may have their Scope of Clinical Practice limited to a particular specialty or surgeon;

(d) may participate in continuing education activities of the Service; and

(e) are not members of the Medical Association.

Consultant Emeritus:

(a) may not admit patients unless they also are Accredited under a classification which authorises patient admission and treatment;

(b) may consult to other practitioners on the care of their patients within their Scope of Clinical Practice;

(c) may participate in continuing education activities of the Service; and

(d) are members of the Medical Association but have no voting rights unless they also have an Accreditation Category to which voting rights attach.

General Practitioners, General Practitioners (Obstetrics) and General Practitioners (Anaesthetics):

(a) may not admit patients except at the absolute discretion of the Board;

(b) may participate in continuing education activities of the Service; and

(c) are not members of the Medical Association unless the Board has approved a Scope of Clinical Practice which includes admission of patients.

Hospital Medical Practitioners:

(a) may not admit patients under their own authority, but may initially admit a patient with the specific authority of an Accredited Practitioner who:

  (i) is authorised to admit patients;

  (ii) has agreed to assume responsibility for the patient's treatment; and

  (iii) undertakes to personally see the patient as clinically indicated but in all circumstances within 48 hours of admission;

(b) may participate in continuing medical education activities of the Service; and

(c) are not members of the Medical Association.

Allied Health Practitioners, Nurses and Midwives:

(a) may not admit patients;

(a) may treat admitted and non-admitted patients who are under the care of an Accredited Practitioner, within their Scope of Clinical Practice;

(b) may consult to other practitioners on the care of their patients within their Scope of Clinical Practice;

(c) may participate in continuing education activities of the Service; and

(d) are not members of the Medical Association.

Midwife Practitioners and Nurse Practitioners:

(a) may not admit patients except at the absolute discretion of the Board;

(b) must assume responsibility for the clinical care of patients admitted under their care (if applicable);

(c) may consult to other practitioners on the care of their patients within their Scope of Clinical Practice;

(d) must participate in continuing education activities of the Service; and

(e) are not members of the Medical Association.