ALBURY DAY SURGERY

APPLICATION FOR VISITING MEDICAL OFFICER

New Application Renewal/reapplication Altered Scope of practice

Please complete all particulars and return to:

Albury Day Surgery
PO BOX 970
ALBURY 2640
OR
shaley@alburydaysurgery.com.au

PLEASE ATTACH TO THIS FORM:

All Applications / Reapplications MUST have a copy of the following:

- Copy of Current medical indemnity Insurance certificate
- Copy of Current medical registration
- Police Check and working with Children Check (if Applicable)
- Copies of relevant Visa documents (If Applicable)
- Current evidence of basic life support and Aseptic technique competencies
- CPD
  Current Copy of Hand hygiene Certificate
  https://www.hha.org.au/online-learning/learning-module-information
- Current Immunisation history-including Covid 19 vaccinations (if not previously provided)

New Appointments Only

- Current curriculum Vitae
- Police Check and working with Children Check
- Certified copies of all specialist or other qualifications
- Proof of identification – 100 points
- Current Immunisation history including Covid 19 Vaccinations

NAME OF MEDICAL PRACTITIONER

Surname: _____

First Name: _____

1. Application for scope of practice

I wish to apply for the scope of practice for: **Surgeon** **Anaesthetist** **Surgical Assistant**

Speciality:

_____

2. Applicant contact details

Surname: _____

First Name: _____

Date of Birth: _____

Place of Birth: _____

Address:

Residential: _____

State: _____ Post Code: _____

Phone Number: _____

Mobile: _____

Email address: _____

Next of Kin Name and Contact _____

Professional: _____

State: _____ Post Code: _____

Phone Number: _____

Mobile: _____

Email address: _____

Do you have a Medicare Provider Number for us at this Location? Yes No

Site/s_____

Provider Number/s_____
(If No- please note that you will be required to have one- Our Organisation can assist)

If Yes, Is it subject to any restrictions *(please provide details below)*

_____

_____

_____

Do you have a Prescriber Number? Yes No
Prescriber Number: _____

3. All qualifications including your primary medical degree

QUALIFICATIONS – UNIVERSITY OR COLLEGE:

Name and Location of Institute:

_____

Degree, Diploma or Certificate:

_____ Date obtained: _____

_____ Date obtained: _____

_____ Date obtained: _____
_____ Date obtained: _____

HOSPITAL AND OTHER APPOINTMENTS HELD:

Previous:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Current:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

EDUCATION ACTIVITIES:

Details of Courses, Congresses etc. attended in the past three years (exclude obstetrics)

_____ Date: _____

_____ Date: _____

_____ Date: _____

PUBLICATIONS, PRESENTATIONS OR PAPERS:

_____

_____

_____

_____

_____

_____

_____

4. Medical Registration and other matters

What is your Medical Registration number: _____

(Please circle either Yes or No)

- Have you ever been formally disciplined (By an employer or other organisation) In the course of your work as a medical practitioner? YES NO
- Do you currently have any conditions or restrictions placed on your registration or your clinical practice? YES NO
- In the past have you had any conditions or restrictions placed on your registration or your clinical practice? YES NO
- Have you ever been denied a scope of clinical practice that you requested? YES NO
- Have you ever chosen to reduce your scope of practice? YES NO
- Has your right to practice ever been withdrawn, suspended, terminated or reduced by any organisation, Employer or professional body? YES NO
- Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence? YES NO
- Have you had any serious illness and do you suffer from any disability likely to affect the full performance of your duties? YES NO
- Do you have current evidence of competency in basic life support training and aseptic technique? YES NO (please be aware that this must be updated and evidence provided annually)

If yes to any of the previous please provide details or you may provide the information in a sealed envelope marked "CONFIDENTIAL for the CEO only" appended to this application and indicate here that additional information is provided separately in this manner.

_____

_____

_____

5. Medical indemnity insurance information

Details of current insurance cover

Name of Insurer: _____

Policy: _____

Number: _____

Expiry Date: _____

- Is your proposed scope of medical clinical practice reflected in or covered by your current Medical indemnity insurance? YES NO NOT APPLICABLE

- Has there ever been, or are there currently pending medical Indemnity claims, settlements or judgements against you? YES NO

- Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage? YES NO

If the answer is yes to any of the above questions please provide details?

_____

_____

6. Clinical Privileges Sought:

Outline the nature of clinical privileges sought for Day Surgery.

_____

_____

_____

_____

_____

REFEREES (New applicants only – At least two Referees)

1: NAME: _____ PHONE NUMBER: _____

ADDRESS_____

2: NAME: _____ PHONE NUMBER: _____

ADDRESS_____

3: NAME: _____ PHONE NUMBER: _____

ADDRESS_____

7. Declaration by Applicant

I fully understand that any significant mis-statement or omission from this application may constitute a case for denial of appointment or cause for dismissal from the Visiting Medical Staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application as a Visiting Medical Officer, I acknowledge my obligation to provide conscientious care to my patients and I acknowledge that I have read the By-Laws and rules of the hospital and I agree to be bound by the terms thereof should I be appointed.

Further by applying for appointment as a Visiting Medical Officer I hereby signify my willingness to appear for interviews in regard for my application. I hereby authorise Albury Day Surgery Administration and Medical Advisory Committee to consult with the Medical Administrators and the members of the Medical Staff of the Hospitals and Institutions with which I have been associated with. I also authorise others who may have information bearing on my professional performance, competence, character and qualifications, in order that my application for appointment be properly assessed.

SIGNATURE: _____ DATE: _____