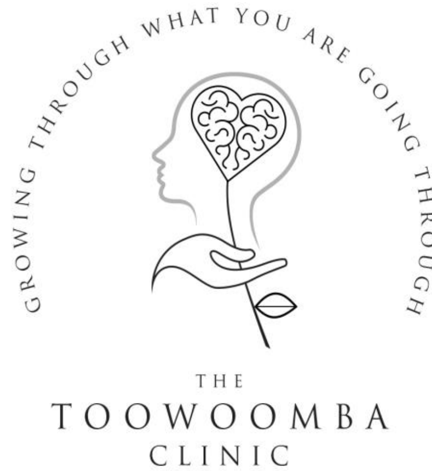

Credentialing and Scope of Clinical Practice Application Form

Application for appointment and scope of clinical practice for an accredited practitioner. Please type or print, tick all relevant boxes and sign the form.

PRIVATE & CONFIDENTIAL

☐ **NEW APPLICATION** *Must be accompanied by Curriculum Vitae, proof of AHPRA registration and professional indemnity insurance, and two written references*
☐ **RENEWAL APPLICATION** *Application form only*

Preferred Title	
Given Names	
Preferred Name	
Surname	
Previous Name	
Date of Birth	
Home Address ☐ Mailing address	
Preferred contact number	
Email (business)	
Email (personal)	
Emergency Contact Person	
Relationship	
Practice Name (1)	

Business Address ☐ Mailing address			
Practice Name (2)			
Business Address ☐ Mailing address			
Name of Partner/Spouse (for Clinic invitation list)			
AHPRA REGISTRATION			
Registration Number			
Category			
Are there any conditions or undertakings currently attached to this registration?		☐ Yes	☐ No
Have you ever been registered as a medical practitioner in another country?		☐ Yes	☐ No
If yes, please give details:			
Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board or other registration board in Australia or another country?		☐ Yes	☐ No
If yes, please give details:			
PROFESSIONAL INDEMNITY			
Indemnity Insurance Company			
Indemnity Insurance Number			

Category of Coverage		Expiry date	/ /
Does your membership fully cover the scope of clinical practice you have applied for?		☐ Yes	☐ No
Has your medical defence insurer or any medical defence insurer or fund which you have been a member ever applied conditions or refused to renew your cover or membership in part or full?		☐ Yes	☐ No
Are there any current claims for compensation against you?		☐ Yes	☐ No
Are you aware of any complaints lodged with AHPRA or the Health Ombudsman?		☐ Yes	☐ No
If yes, please give details:			

CATEGORY OF CLINICAL PRACTICE SOUGHT

☐ Specialist Medical Practitioner
☐ General Medical Practitioner
☐ Allied Health Practitioner

PRIVILEGES SOUGHT

☐ Admitting
☐ Consulting
☐ Procedural (rTMS or ECT)

SCOPE OF CLINICAL PRACTICE BEING SOUGHT

☐ Psychiatry – General adult and ECT (Level 5)
☐ General Medicine Consulting

REFEREES

Referee 1	Name:
	Current Position:
	Address:
	Phone: Fax:
	Mobile:
	Email:
	Relationship:(i.e. Line manager, Professional Peer etc)
Referee 2	Name:

	Current Position:
	Address:
	Phone: Fax:
	Mobile:
	Email:
	Relationship:(i.e. Line manager, Professional Peer etc)

CLINICAL APPOINTMENTS		
Organisation	***Appointment***	***Dates***
		to
		to
		to
		to
		to
		to
		to
		to
		to
		to

PROFESSIONAL AFFILIATIONS		
Are you a member of any specialist Colleges or Associations? *Please list*	☐ Yes	☐ No

CONTINUING PROFESSIONAL DEVELOPMENT & QUALITY		
Have you met the continuing professional development requirements of the Medical Board of Australia or other relevant Board (allied health)?	☐ Yes	☐ No
Have you participated in regular clinical reviews, audits and or peer review activities in the clinical setting?	☐ Yes	☐ No
Are you prepared to conduct grand rounds or other educational activities at The Toowoomba Clinic?	☐ Yes	☐ No

HEALTH STATUS		
Do you have a disability or health issues that:		
• May impact on your ability to perform any of the cognitive or physical functions that would fall within the scope of practice that you are seeking in this application?	☐ Yes	☐ No
May require special equipment, facilities of work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?	☐ Yes	☐ No
DECLARATION AND AGREEMENT		
I understand that The Toowoomba Clinic in assessing my application for appointment as a medical practitioner or allied health practitioner, The Toowoomba Clinic will make additional enquiries as to my suitability for the position.		
I understand The Toowoomba Clinic will conduct a routine police check.	☐ Yes	☐ No
I authorise The Toowoomba Clinic to seek information from my referees as to my past experience, performance and current fitness to practise.	☐ Yes	☐ No
I agree to familiarise myself with the relevant hospital by-laws, policies and procedures and abide by them.	☐ Yes	☐ No
I accept that the health service will obtain information relevant to my application from the Medical Board of Australia or any other authority that regulates health practitioners.	☐ Yes	☐ No
I authorise The Toowoomba Clinic to obtain information relevant to my application from my current and any previous medical or professional indemnity organisation/insurer.	☐ Yes	☐ No
I authorise The Toowoomba Clinic to obtain information relevant to my supervision requirements (where applicable).	☐ Yes	☐ No
I authorise The Toowoomba Clinic to seek information from other persons as The Toowoomba Clinic considers appropriate, including any relevant health service, college or other professional organisation.	☐ Yes	☐ No

I agree to abide by the organisation's and State and National confidentiality and privacy laws and policies and understand that breaches may result in cessation of my appointment.	☐ Yes	☐ No
I agree to notify the CEO/DON, The Toowoomba Clinic of any event or situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the Clinical Director would wish to be informed and as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).	☐ Yes	☐ No
I agree to support and participate in The Toowoomba Clinic's performance development activities.	☐ Yes	☐ No
I agree to promptly notify the CEO/DON, The Toowoomba Clinic of any adverse clinical incident I am involved in or become aware of.	☐ Yes	☐ No
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	☐ Yes	☐ No
Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	☐ Yes	☐ No
I understand that my appointment will be reviewed in one (1) year and five (5) years for re-appointments or earlier as considered necessary.	☐ Yes	☐ No

Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of Applicant Date: / /

Witness Signature:

Witness Name:

Date:

Please refer to the following Checklist for completion of Application

Applicant Checklist – *Have you attached the necessary information/documents*
Certified copy of identification documents ☐ Yes ☐ No
Identification documents attached ☐ Yes ☐ No
Provider Number ☐ Yes ☐ No
Prescriber Number ☐ Yes ☐ No
Certified copy of medical registration ☐ Yes ☐ No
Certified copy of current medical indemnity insurance cover (current) ☐ Yes ☐ No
Certified copy of qualifications ☐ Yes ☐ No
Attached two recent referee reports ☐ Yes ☐ No
Curriculum Vitae attached ☐ Yes ☐ No
Provided details of Continuing Professional Development activities ☐ Yes ☐ No
Declaration of Health status ☐ Yes ☐ No
Signed declaration ☐ Yes ☐ No

OFFICE USE ONLY

Applicant Name:			
Item	**Check**	**Yes/No**	**Comments**
1	**Identification 100 points**	☐ **Yes** ☐ **No**	
2	**Contact details**	☐ **Yes** ☐ **No**	
3	**Qualifications**	☐ **Yes** ☐ **No**	
5	**CV Attached**	☐ **Yes** ☐ **No**	
6	**Previous appointments cross referenced with application/referee/CV**	☐ **Yes** ☐ **No**	
7	**CPD certificate/summary**	☐ **Yes** ☐ **No**	
8	**Medical Indemnity Insurance**	☐ **Yes** ☐ **No**	
9	**Medical Registration APHRA Check**	☐ **Yes** ☐ **No**	
10	**Web search**	☐ **Yes** ☐ **No**	
11	**Referee Checks**	☐ **Yes** ☐ **No**	

Application Checked by:

Name:____
Signature:_____________________________________

Date: / /

Recommendation: The Credentialing Committee recommends/declines the application for credentialing for:

Category of Clinical Practice Sought	**Privileges Sought**	**Scope of Clinical Practice Sought**
☐ Specialist Medical Practitioner ☐ General Medical Practitioner ☐ Allied Health Practitioner	☐ Admitting ☐ Consulting ☐ Procedural (rTMS or ECT)	☐ Psychiatry – General adult and ECT (Level 5) ☐ General Medicine Consulting

Application checked by:		
Signature:		
Date:		
Letter to applicant advising of outcome of application	☐ Yes	☐ Copy attached