

Passport photo
 must accompany
 application

Application for Accreditation and Clinical Privileges

Please complete all fields. Incomplete fields will lead to delays

(You may submit by post, fax, or email. Please see *Submission* at end of form)

1. Personal Details

Title & Surname		Given Name(s)	
Date of Birth			
Business Name & Address			
		Postcode	
Private Address			
		Postcode	
Email Address			
Business Phone		Home Phone	
Mobile:		Fax No	

Please indicate with an asterix, preferred first contact number

2. Qualifications & Curriculum Vitae

	Qualification	Year	Granting Body
1			
2			
3			

Please attach or email your CV detailing your medical education & training, past and current appointments, courses undertaken, publications & presentations and special interests if any.

Attached Emailed

3. Registration & Maintenance of Professional Standards

Are you currently registered to practise in the State of Western Australia?

Yes No

If **YES** quote Registration Number:

Is your registration: General Conditional Provisional

If *Conditional or Provisional*, under what section of the Medical Act?:

*Where applicable, attach copy of licence or certification required for the speciality
 eg: Radiology Licence, Conjoint Committee for Recognition in Training in GI Endoscopy*

Attached Not applicable

Professional Standards

- Have you been subjected to denial, suspension, termination or withdrawal of the right to practise in any other organisation?

If **Yes** provide full details in Supporting Information at end of form. Yes No

- Have you been subjected to any disciplinary action or professional sanctions imposed by any registration board, HIC, regulatory authority or similar body?

If **Yes** provide full details in Supporting Information at end of form. Yes No

- Are you currently participating in a Continuing Professional Development (CPD) Program?

Yes No If **YES** quote name of Program:

- Have you subjected your clinical work to quality assurance processes including clinical audit and peer review?

Yes No

- Are you prepared to subject your work to quality assurance processes, including clinical audit and peer review on an ongoing basis?

Yes No

4. Medical Indemnity Insurance

Are you currently a member of a medical indemnity insurance organisation? Yes No

If **YES** provide details/name of organisation:

Membership No:

Category of Cover:

Please attach a copy of the receipt showing current indemnity cover

Attached

5. Hospital Privileges Sought

General Practice

- Admitting Privileges Obstetrics

Internal Medicine

- Admitting Privileges G-I Endoscopy ERCP
 Bronchoscopy Oncology Clinical Haematology

Anaesthesia

- General Obstetric Paediatric
 Regional & Epidural Pain Management Younger than 12 months

Surgery

- General Orthopaedic Endoscopic (any speciality)
 Paediatric Gynaecology Dental
 Vascular Urology Ophthalmology
 ENT Plastic Surgery

Diagnostic

- Pathology Nuclear Medicine Radiology
 Diagnostic Cardiology Ultrasound Respiratory Medicine

Obstetrics

- Admitting Privileges

Paediatrics

- Surgical Neonatal Nursery

6. Clinical Privileges Requested

Please detail the nature of procedures to be performed if any, (eg – Laparoscopic Surgery)

Please state any procedure not normally considered part of your specialty for which you are applying (eg - Caesarean Section or ORIF for General Surgeons):

Operating & Endoscopy Suites

Provide for (1) each Procedure, preferred (2) Day & (3) AM or PM:

7. Accreditation for Advanced Surgical Techniques

An Advanced Surgical Procedure is defined as a new surgical technique not currently widely practised within the Australian community.

Type of Procedure(s) to be performed:

Have you completed specific training for such Procedure(s)? Yes No

If **Yes** provide details and attach certification. Attached Not applicable

How many of these Procedures have you performed? List below Procedure and number.

Have you had any adverse outcomes with these procedures? Yes No

If **Yes** provide details

Does your medical indemnity insurance cover you for this procedure(s)? Yes No

Please be aware of informed consent responsibilities

8. Health

- In the past 12 months have you worked in, or been admitted to, a Hospital **overseas** or **interstate in Australia** or **outside the Perth Metropolitan area**? Yes No

If **Yes** please provide a copy of current MRSA clearance. Attached Not applicable

- Have you been immunized against rubella and pertussis (obstetrics service only)? Yes No

If **Yes** please provide evidence of immunity. Attached Not applicable

If No, Boostrix Vaccine is offered to non-immune staff

- Have you any physical or other condition that may limit your ability to practise your discipline? Yes No

If **Yes**, please comment below:

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9. Colleague as First Contact in the Event of Your Unavailability

Please nominate a colleague who has the appropriate skills and experience and is accredited by the Hospital to cover for your patients when you are unavailable.

Title & Surname		Given Names	
Address			Postcode
Telephone		Mobile	
Fax		Email	

10. Referees

Please nominate three medical referees who are readily contactable and professionally familiar with you. At least two should be of the same discipline.

Title & Surname		Given Names	
Address			Postcode
Telephone		Email	
Title & Surname		Given Names	
Address:			Postcode
Telephone		Email	
Title & Surname		Given Names	
Address:			Postcode
Telephone		Email	

11. Check List and Supporting Information

Please forward in a separate sheet any other information that you may wish to add to support your application (eg additional qualifications, appointments, training, and experience).

Please use the checklist below to ensure that you have provided all information and attached the required documents.

Checklist

- Completed all fields? Omissions will lead to delays in accreditation.
- Attached or emailed your CV? (S2)
- Quoted your Medical Board WA Registration Number? (S3)
- Quoted details on General/Conditional/Provisional Registration? (S3)
- Attached special licence/certification if relevant? (S3)
- Attached a copy of receipt of Medical Indemnity Insurance? (S4)
- Attached certification of training for an advanced surgical technique? (S7)
- Attached MRSA clearance if relevant? (S8)
- For obstetrics services, attached evidence of rubella and pertussis immunity? (S8)

12. Declaration

- I agree to abide by the policies of the Medical Board of Western Australia.
- I authorise the Credentials Committee to verify with relevant individuals, external organisations and nominated referees the validity of all claims made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history and criminal record.
- I hereby authorise Mercy Hospital to obtain details annually of Medical Indemnity from my Insurer, and of CPD from my nominated College or Professional Association.
- I declare that the statements contained in this application are correct and true.
- I agree to abide by the By-Laws of this Hospital and in on-call roster arrangements and any terms and conditions which relate to my appointment. (The By-Laws are available at <http://www.mercycare.com.au/resources/MercyHospitalMountLawleyBy-Laws.pdf>)

Signature:

Print Name:

Date:

*Accreditation and Clinical Privileges may be granted as **Temporary Accreditation** for a period up to three months, after which time **Full Accreditation** may be granted for a period of up to one year. Re-accreditation may be offered upon receipt and review of an application at the end of your appointment period. An incomplete application may be granted **Provisional Accreditation** for up to one month.*

The Hospital reserves the right to vary or withdraw your Accreditation and Clinical Privileges. There is a right of appeal to a separate Review Committee on all matters relating to Accreditation and Clinical Privileges.

Submission

Please forward by post, fax or email (with electronic signature and scanned additional attachments) to:

Professor Teik E. Oh

Director Medical Services

Mercy Hospital Mount Lawley

Thirlmere Road

Mt Lawley, WA 6050

Email: sgray@mercycare.com.au

Phone: 9370 9856

Fax: 9272 1229

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