



Application for Accreditation as a Surgical Assistant

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

	Qualification	Year	Granting Body
1			
2			

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?:

- 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 an attachment.

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 an attachment.

Yes No

4. Medical Indemnity Insurance

Details/name of organisation:

Membership No:

Category of Cover:

Please attach a copy of the receipt showing current indemnity cover

Attached

5. Accredited Surgeon(s)

Please provide the names(s) of **accredited** surgeons that you are applying to assist

Title & Surname	Given Name(s)	Specialty

6. Health

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

If **Yes** please provide a copy of current MRSA clearance. Attached No applicable

7. 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 or external organisations my declaration regarding health status and registration history, and to obtain details annually of Medical Indemnity from my Insurer.
- 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:

8. Supporting Accredited Surgeon(s)

(Must be signed by every surgeon who will be assisted by applicant).

I endorse this applicant for accreditation as a Surgical Assistant to assist me under my oversight and responsibility. I have Full Accreditation at Mercy Hospital.

Name	Signature	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 on all matters relating to Accreditation and Clinical Privileges.

Submission

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

Professor Teik E Oh
Director Medical Services
Mercy Hospital
Thirlmere Road
Mt Lawley WA 6050

Email: sgray@mercycare.com.au
Phone: 9370 9856
Fax: 9272 1229

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