



RENEWAL APPLICATION FOR CLINICAL PRIVILEGES

For use by all Medical/Dental Practitioners seeking a renewal of their accreditation at the Burnside Hospital

Please submit the completed medical application form, together with the required supporting documentation, to Mr Nick Warden, Chief Executive, Burnside War Memorial Hospital. An electronic copy is available from Ms Luisa Mozzi on (08) 8202 7208 or email: lmozzi@burnsidehospital.asn.au

SURNAME OF APPLICANT

GIVEN NAME(S) IN FULL

Date of Birth:/...../.....

Name of Partner or Spouse (Optional) (For hospital invitation list)

RESIDENTIAL ADDRESS

..... Post Code

Residential Telephone: Residential Fax:

PROFESSIONAL ADDRESS

.....

..... Post Code

Telephone: Fax:

Mobile:

Pager No:.....

Email:

Provider No:.....

ACCREDITATION SOUGHT AT BURNSIDE HOSPITAL (Please tick relevant category)

Specialist Practitioner

Consultant Emeritus (no admitting rights)

General Practitioner

Consultant Specialist/General Practitioner (no admitting rights)

Surgical Assistant (no admitting rights)

Approval to undertake approved medical research &/or clinical trials

Permanent

Temporary for a period from to

QUALIFICATIONS

Please provide details of any **new** qualifications since previous renewal | application.

Qualification	Authorising Body	Date Obtained

CLINICAL PRIVILEGES ARE SOUGHT IN THE FIELD(S) OF: (please tick)

<input checked="" type="checkbox"/> Anaesthesia <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Obstetric <input type="checkbox"/> Neonatology <input type="checkbox"/> Palliative Care	<input checked="" type="checkbox"/> Obstetrics/Gynaecology <input type="checkbox"/> Obstetrics <input type="checkbox"/> Gynaecology General <input type="checkbox"/> Neonatology <input type="checkbox"/> Advanced Endoscopic Surgery (provide evidence of AGES training)	Refer to Training Levels (RANZCOG Guide)
<input checked="" type="checkbox"/> Colorectal Surgery <input type="checkbox"/> Laparoscopic <input type="checkbox"/> General	<input checked="" type="checkbox"/> General Surgery <input type="checkbox"/> Endoscopy <input type="checkbox"/> Laparoscopic <input type="checkbox"/> Paediatric <input type="checkbox"/> Adult	
<input checked="" type="checkbox"/> Orthopaedic Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric	<input checked="" type="checkbox"/> ENT Surgery <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> Paediatric Endoscopy <input type="checkbox"/> Head and Neck	<input checked="" type="checkbox"/> Vascular Surgery <input type="checkbox"/> Adult <input checked="" type="checkbox"/> Ophthalmology <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric
<input checked="" type="checkbox"/> Urology <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric	<input checked="" type="checkbox"/> Dermatology <input type="checkbox"/> Adult	<input checked="" type="checkbox"/> General Practice <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric
<input checked="" type="checkbox"/> Dental <input type="checkbox"/> Oral & maxillofacial	<input checked="" type="checkbox"/> Oral & Maxillofacial Surgery <input type="checkbox"/> Adult	<input checked="" type="checkbox"/> Gastroenterology <input type="checkbox"/> Endoscopy <input type="checkbox"/> ERCP
<input checked="" type="checkbox"/> Oncology <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Gynaecology Oncology	<input checked="" type="checkbox"/> Plastic & Reconstructive Surgery <input type="checkbox"/> Hand Surgery <input type="checkbox"/> Facio Maxillary <input type="checkbox"/> Plastic Reconstructive <input type="checkbox"/> Head and Neck <input type="checkbox"/> Minor skin lesions	
<input checked="" type="checkbox"/> Physician		
<input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology and Hepatology <input type="checkbox"/> General Medicine <input type="checkbox"/> General Paediatrics <input type="checkbox"/> Haematology <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Infectious Diseases and Microbiology	<input type="checkbox"/> Intensive Care Medicine <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Palliative Medicine <input type="checkbox"/> Rheumatology <input type="checkbox"/> Respiratory and Sleep Medicine <input type="checkbox"/> Other:	
<input checked="" type="checkbox"/> Other (please list)		
<input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Radiologist <input type="checkbox"/> Pathologist (please specify)		

SPECIAL NOTES

Applicants for **Advanced Endoscopic Surgery** are required to provide details of experience, qualifications & education verifying their competence with the equipment and the procedure. Please attach relevant details to this application form.

All accredited practitioners with Clinical Privileges must be able to demonstrate participation in programs to maintain and improve the quality of care they give to patients so as to guarantee the highest possible clinical standards of care to the patients admitted to the Burnside Hospital, including but not limited to participation in recognised quality assurance and clinical risk reduction activities, recognised continuing medical education and **professional development activities**. Accredited Practitioners must also be able to confirm that they undertake regular work of an appropriate volume and complexity as is necessary to maintain proper clinical standards of practice in the fields in which they have clinical privileges at the Burnside Hospital.

The requirements of the various medical colleges will be taken to mean the appropriate volume. In the event the appropriate volume is not specified by the relevant medical college the Clinical Privileges Review Committee shall determine the level which is to apply.

Applicants wishing to undertake approved **medical research and/or clinical trials** at the Burnside Hospital are required to provide to the Hospital annually a list of current and proposed research/clinical trials for notification to the hospital's indemnity insurer.

Surgeons allocated operating lists at the Burnside Hospital are expected to fully utilise such sessions with the exception of notified periods of leave. Surgeons with operating lists are required to provide Burnside Hospital at least 48 hours notice of their inability, probable or otherwise, to commit to a scheduled operating list. Burnside Hospital reserves the right to withdraw allocated lists if utilisation falls below an acceptable level.

AFTER HOURS/EMERGENCY CARE PROVISIONS (Complete only if different from last renewal | application.)

Please provide details of a registered / nominated practitioner from the same discipline who is accredited at Burnside Hospital who can be contacted for "back up" or "emergency" cover, should the Hospital be unable to contact you.

First Name: Last Name

Address:

Telephone:After Hours Telephone

Mobile Phone.....Pager (Tel No.)Page No.

PHYSICIAN CONTACT (Surgeons only to complete) (Complete only if different from last renewal | application.)

Please provide details of a registered / nominated physician who is accredited at Burnside Hospital and who can be contacted by the Hospital if required regarding the medical management of your patients. If unable to provide details please advise the Clinical Manager at the time of patient's admission.

First Name: Last Name

Address:

Telephone:After Hours Telephone

Mobile Phone.....Pager (Tel No.)Page No.

REFEREES

For the specialty in which you are seeking privileges please provide names, addresses and telephone numbers of three peer referees in Australia who can attest to your recent practice (within the previous five years) and who are not professionally or financially related to you.

Referees:

(1) Name:

Contact Details:

(2) Name:

Contact Details:

(3) Name:

Contact Details:

MEDICAL REGISTRATION

I am currently registered with the Medical Board of South Australia and/or the Dental Board of South Australia.

Registration No: _____

S/N (if applicable): _____

Expiry date: _____

Attached is a copy of my current registration certificate.

Please note that if you are also a **director** or **shareholder** of a company registered with the Medical Board of South Australia and/or the Dental Board of South Australia, then a photocopy of the current registration certificate of the company must also be attached.

OTHER INFORMATION

1. Have you ever been subject to an adverse finding or had conditions attached to your registration by a medical board/dental board?

Yes/ No If, yes give dates and particulars:

2. **Have you ever been found guilty of medical negligence or professional misconduct?** This information is required to assess an application for clinical privileges and will only be used by Burnside Hospital for such purposes and will not be disclosed otherwise.

Yes/No: If yes, give dates and particulars. Please note that you may be contacted for a confidential report.

3. **Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked or have had conditions attached to that appointment for any reason?**

Yes/No If yes, give dates and particulars.

4. **Have you ever been convicted of a sex or violence offence or any offence in relation to your practice as a medical or dental practitioner?**

Yes/No If yes, please give date of conviction and particulars.

5. **Are you currently under investigation by a medical board, dental board or hospital?**

Yes/No If yes, please give particulars

PROFESSIONAL INDEMNITY INSURANCE

Please state the name of your medical defence union or fund or your professional indemnity insurance provider and provide a photocopy of current membership.

Provider:

Membership Number:.....

Does the membership fully cover the types of privileges you have applied for? Yes/No

Expiry date:

AUTHORITY

I authorise Burnside Hospital to obtain information on an annual basis from the registration body / indemnity insurance organisation as nominated in this application, regarding the currency of my registration / membership of that body / organisation.

SPECIALIST DIRECTORY

I authorise Burnside Hospital to include my details in the hospital's Specialist Directory: **Yes / No**

CRIMINAL RECORD CHECK

I agree, if requested, to provide Burnside Hospital with such Police check reports as it requires.

NOTIFICATION OF PLANNED ABSENCES

I agree to provide Burnside Hospital with sufficient prior notice regarding planned absences eg annual, conference, sick or other leave, to enable the hospital to make suitable alternative arrangements in regard to utilisation if required.

COMPLIANCE WITH BY LAWS, RULES AND COVENANTS

I agree to comply with the Medical Staff By Laws and Rules for Visiting Medical Staff Association, the Burnside Hospital - Schedule of Covenants and the Emergency Management Information for Visiting Medical Officers, copies of which I acknowledge having received.

NOTIFICATION

I agree to promptly notify Burnside Hospital:

1. If my clinical privileges at any other hospital or day procedure centre are reduced, suspended, revoked or have conditions attached; and
2. Of anything that adversely impacts on my ability to comply with the Medical Staff By Laws and Rules for Visiting Medical Staff Association and the Burnside Hospital - Schedule of Covenants.

AUTHORISATION

I authorise Burnside Hospital, its officers and the Clinical Privileges Review Committee to conduct such checks and to obtain such information as it requires in respect of my past experience, performance and fitness for accreditation.

DECLARATION

I declare:

1. **that the information and statements in this application are true and correct; and**
2. **that I am not aware of any other information which may be relevant to Burnside Hospital in assessing this application for accreditation.**

I HEREBY APPLY FOR APPOINTMENT TO THE MEDICAL / DENTAL STAFF OF THE BURNSIDE HOSPITAL WITH PRIVILEGES IN THE FIELD(S) NOMINATED IN THIS APPLICATION.

SIGNATURE:.....

PRINT NAME:

DATE:



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Paediatric	Gynaecology General	
Obstetric	Neonatology	
Neonatology	Advanced Endoscopic Surgery (provide evidence of AGES training)	
Palliative Care		
<input checked="" type="checkbox"/> Colorectal Surgery	<input checked="" type="checkbox"/> General Surgery	<input checked="" type="checkbox"/> Vascular Surgery
Laparoscopic	Endoscopy	Adult
General	Laparoscopic	<input checked="" type="checkbox"/> Ophthalmology
	Paediatric	Adult
	Adult	Paediatric
<input checked="" type="checkbox"/> Orthopaedic Surgery	<input checked="" type="checkbox"/> ENT Surgery	<input checked="" type="checkbox"/> General Practice
Adult	Adult	Adult
Paediatric	Paediatric	Paediatric
	Paediatric Endoscopy	
	Head and Neck	
<input checked="" type="checkbox"/> Urology	<input checked="" type="checkbox"/> Dermatology	<input checked="" type="checkbox"/> Gastroenterology
Adult	Adult	Endoscopy
Paediatric		ERCP
<input checked="" type="checkbox"/> Dental	<input checked="" type="checkbox"/> Oral & Maxillofacial Surgery	<input checked="" type="checkbox"/> Plastic & Reconstructive Surgery
Oral & maxillofacial	Adult	Hand Surgery
<input checked="" type="checkbox"/> Oncology		Facio Maxillary
Radiation Oncology		Plastic Reconstructive
Gynaecology Oncology		Head and Neck
		Minor skin lesions
<input checked="" type="checkbox"/> Physician		
Endocrinology		Intensive Care Medicine
Gastroenterology and Hepatology		Medical Oncology
General Medicine		Palliative Medicine
General Paediatrics		Rheumatology
Haematology		Respiratory and Sleep Medicine
Infectious Diseases		Other:
Infectious Diseases and Microbiology		
<input checked="" type="checkbox"/> Other (please list)		
Surgical Assistant		
Radiologist		
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SIGNATURE:.....

PRINT NAME:

DATE: