CLINICAL PRIVILEGES APPLICATION FORM

For use by all Medical/Dental Practitioners seeking 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

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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 ………………………**

UNDERGRADUATE QUALIFICATIONS, UNIVERSITY AND YEAR OF GRADUATION

Qualification	University	Date Graduated

POSTGRADUATE QUALIFICATIONS, UNIVERSITY AND YEAR OF GRADUATION

Qualification	Authorising Body	Date Obtained

Special Comments on Post Graduate Experience (or attach current CV)

....

....

REGISTERED SPECIALITY/SUB SPECIALITIES

....

....

ITEMISE POST GRADUATE EDUCATIONAL ACTIVITY IN THE PAST 3 YEARS (OR ATTACH CV)

....

....

NATURE OF CURRENT PRACTICE, PLACE OF WORK AND SPECIAL PROFESSIONAL INTERESTS.

....

....

....

CURRENT/PAST APPOINTMENTS AT OTHER HOSPITALS OR DAY PROCEDURE CENTRES

Name	Current/Past

MEMBERSHIP OF COLLEGES AND/OR OTHER RELEVANT ASSOCIATIONS

1. ....

2. ....

3. ....

PUBLICATIONS (Please attach list or Curriculum Vitae)

....

....

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

✓	**Anaesthesia**
	Adult
	Paediatric
	Obstetric
	Neonatology
	Palliative Care

✓	**Obstetrics/Gynaecology**	
	Obstetrics	
	Gynaecology General	
	Neonatology	
	Advanced Endoscopic Surgery (provide evidence of AGES training)	**Refer to Training Levels (RANZCOG Guide)**

✓	**Colorectal Surgery**
	Laparoscopic
	General

✓	**General Surgery**
	Endoscopy
	Laparoscopic
	Paediatric
	Adult

✓	**Vascular Surgery**
	Adult

✓	**Ophthalmology**	
	Adult	Paediatric

✓	**Orthopaedic Surgery**
	Adult
	Paediatric

✓	**ENT Surgery**
	Adult
	Paediatric
	Paediatric Endoscopy
	Head and Neck

✓	**General Practice**
	Adult
	Paediatric

✓	**Urology**
	Adult
	Paediatric

✓	**Dermatology**
	Adult

✓	**Gastroenterology**
	Endoscopy
	ERCP

✓	**Dental**
	Oral & maxillofacial
✓	**Oral & Maxillofacial Surgery**
	Adult

✓	**Plastic & Reconstructive Surgery**
	Hand Surgery
	Facio Maxillary
	Plastic Reconstructive
	Head and Neck
	Minor skin lesions

✓	**Physicians**
	Sleep
	Respiratory
✓	**Paediatrics**
	Surgery
	Medicine

✓	**Physician/Internal Medicine**
	General Medicine
	Endocrinology
	Rheumatology
	Neurology
	Renal Medicine
	Infectious Diseases

✓	**Oncology**
	Medical Oncology
	Radiation Oncology
	Gynaecology Oncology

✓	**Other (please list)**
	Surgical Assistant
	Radiologist
	Pathologist (please specify)

SPECIAL NOTE:

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.

OTHER PRIVILEGES SOUGHT

Field	Surgical Admitting	Medical Admitting	Consulting	Other (Specify)

SURGICAL ASSISTANTS ONLY TO COMPLETE

Name of accredited practitioner(s) at Burnside Hospital who will provide a reference for you.

Name	Contact Number	Speciality

Name	Contact Number	Speciality

SPECIAL NOTES

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 Patient Care 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 are required to provide Burnside Hospital with sufficient notice of their intention to be absent for any period of time exceeding 48 hours. Burnside Hospital reserves the right to withdraw allocated lists if utilisation is below this requirement.

CLINICAL EXPERIENCE AND COMPETENCE RELATED TO PRIVILEGES SOUGHT

Please detail information relevant to this application only and include data relating to clinical activities and volumes relevant to this application (or attach CV with necessary detail).

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....

....

ITEMISE CLINICAL AUDIT/ PEER REVIEW ACTIVITIES PERSONALLY UNDERTAKEN IN PAST 12 MONTHS (Or attach list)

....

....

....

OPERATING LISTS, PROCEDURES, ITEM NUMBERS, PREFERENCE CARD RE INSTRUMENTATION, SPECIALISED EQUIPMENT AND/OR THE USE OF DISPOSABLE ITEMS

Please note that this information is required to enable Burnside Hospital to make an informed decision regarding its ability to grant the privileges requested in relation to the hospital being able to sustain its business in accord with patient and staff safety considerations, agreements with private health insurers and the sustainable use of its resources. No guarantee to meet your requests is given or implied at this time. Please give sufficient detail to enable your requests to be evaluated fully.

Procedure/Operation and where relevant item numbers	No. of Operating Lists Requested	Specialised Instrumentation	Specialised Equipment	Specialised Disposable Items

**** Please extend this table if additional space is required or add a page as an attachment.***

AFTER HOURS/EMERGENCY CARE PROVISIONS

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)

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 each 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.

SPECIALITY: ....

Referees:

(1) Name:..

Contact Details: ....

(2) Name: ....

Contact Details: ....

(3) Name: ....

Contact Details: ....

SPECIALITY: ....

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: ____

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**:...…………………

Category incl. $ Value & Level of Coverage:..……………………………………………………………...

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 and the Burnside Hospital - Schedule of Covenants, 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: ....