APPLICATION FOR CLINICAL PRIVILEGES

(Specialist | General Practitioner | Surgical Assistant)

Please submit the completed form and supporting documentation to the ***Chief Executive Officer, Burnside Hospital, 120 Kensington Road, Toorak Gardens 5065*** *or via email, accreditation@burnsidehospital.asn.au*
Telephone enquiries can be directed to the Executive Assistant: (08) 8202 7208

APPLICATION: **NEW** ☐ **RENEWAL** ☐

1. APPLICANT AND CONTACT DETAILS

Surname		**Title**
Given Name(s)		
Previous Name (Please include your previous name if it appears on certificates)		
Date of Birth		
Country of Birth		
Residency status: • **Australian Citizen** • **Permanent Resident of Australia**	***YES / NO*** ***YES / NO*** If ***NO***: _____	
Professional Address	*Postcode*	
Telephone: B/H		
A/H | Mobile		
Facsimile:		
Email Address		
Postal Address (if different to Professional Address)	*Postcode*	
Private Address	*Postcode*	
Provider Number		

REQUIRED ATTACHMENTS: ***Please attached the following documents to your application:***	
Current curriculum vitae	
Copy of current Australian Health Practitioner Regulation Agency (AHPRA) registration	
Copy of current medical defence | professional indemnity insurance certificate	
Copies of relevant visa documents (if applicable)	

2. SPECIAL NOTES

• Applicants for Advanced Laparoscopic 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 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.
• Paediatric patients: Burnside Hospital's admission exclusion criteria include paediatric patients less than 10 years of age.

3. APPLICATION FOR CLINICAL PRIVILEGES

a) Category	Specialist Practitioner	☐
	General Practitioner (non-procedural)	☐
	Surgical Assistant	☐

b) Application for scope of practice

☐ **ANAESTHESIA**
- ☐ Adult
- ☐ Obstetric
- ☐ Paediatric (≥ 10 years as per Burnside Hospital admission exclusion criteria)

☐ **DENTAL**
- ☐ General Dentistry
- ☐ Special Needs Dentistry

☐ **DERMATOLOGY**

☐ **ENT SURGERY**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Adenoidectomy
- ☐ Bronchial Procedures
- ☐ Ear Procedures
- ☐ Facial Nerve
- ☐ Laryngeal Procedures
- ☐ Nasal Procedures
- ☐ Otolaryngology – Head & Neck
- ☐ Pharyngeal Procedures
- ☐ Tonsillectomy
- ☐ Tracheal Procedures
- ☐ Other, please specify:

_____

_____

☐ **GASTROENTEROLOGY**
- ☐ Upper Gastrointestinal Endoscopy
- ☐ Colonoscopy
- ☐ Percutaneous Endoscopic Gastrostomy (PEG)
- ☐ Other, please specify:

_____

_____

☐ **GENERAL PRACTICE**
- ☐ Non-procedural

☐ **GENERAL SURGERY**
- ☐ Bariatric
  - ☐ Lap Banding
  - ☐ Modified Roux-en-Y
  - ☐ Sleeve Gastrectomy
  - ☐ Other please specify:

_____

_____

- ☐ Breast Surgery
- ☐ Colorectal Surgery
- ☐ Endocrine Surgery
  - ☐ Adrenalectomy
  - ☐ Thyroidectomy
- ☐ Gastrointenstinal Surgery
- ☐ Hepatobiliary & Pancreatic Surgery
- ☐ Laparoscopic Surgery
- ☐ Sentinel Node Biopsy
- ☐ Upper GI Surgery

☐ **GYNAECOLOGY**
- ☐ Advanced Laparoscopic Surgery
- ☐ Gynaecology General
- ☐ Ultrasound
- ☐ Gynaecological Oncology
- ☐ Uro-Gynaecology

☐ **INTENSIVE CARE MEDICINE**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)

☐ **INTERNAL MEDICINE**
- ☐ Clinical Genetics
- ☐ Clinical Pharmacology
- ☐ Endocrinology
- ☐ Geriatric Medicine
- ☐ Haematology
- ☐ Hepatology
- ☐ Immunology and Allergy
- ☐ Infectious Diseases
- ☐ Medical Oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Respiratory Medicine
  - ☐ Bronchoscopy-Diagnostic
  - ☐ Bronchoscopy- Therapeutic
  - ☐ Sleep Medicine
  - ☐ Other please specify:

_____

_____

- ☐ Rheumatology
- ☐ Other, please specify:

_____

_____

☐ **OBSTETRICS**
- ☐ Maternal Fetal Medicine
- ☐ Obstetrics
- ☐ Ultrasound

☐ **OCCUPATIONAL AND ENVIRONMENTAL MEDICINE**

☐ **OPHTHAMOLOGY**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Cataract Surgery
- ☐ Corneal Transplantation
- ☐ Eyelid Surgery
- ☐ Glaucoma Surgery
- ☐ Lacrimal Surgery
- ☐ Oculoplastic
- ☐ Orbital Surgery
- ☐ Pterygium Surgery
- ☐ Refractive Surgery
- ☐ Squint Surgery
- ☐ Vitreoretinal Surgery

☐ **ORAL MAXILLOFACIAL SURGERY**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Facio Maxillary Surgery
- ☐ Mandibular Osteotomy
- ☐ Other, please specify:

_____

_____

☐ **ORTHOPAEDIC SURGERY**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Arthroscopy
- ☐ Fracture Management
- ☐ Major Joint Replacement
- ☐ Reconstructive Surgery
- ☐ Spinal Surgery

☐ **PAEDIATRIC MEDICINE**
- ☐ General Medicine
- ☐ Neonatology (Special care nursery for a Level 4 Hospital) (34 weeks gestation or later)

☐ **PAEDIATRIC SURGERY**

☐ **PAIN MEDICINE**

☐ **PALLIATIVE MEDICINE**

☐ **PATHOLOGY**
- ☐ Anatomical/Cytopathology
- ☐ Biochemistry
- ☐ Chemical Pathology
- ☐ General Pathology
- ☐ Haematology
- ☐ Immunology
- ☐ Microbiology

☐ **PLASTIC AND RECONSTRUCTIVE SURGERY**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Bat Ears
- ☐ Repair of Lacerations
- ☐ Revision of Scars
- ☐ Abdominal Reductions
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Cosmetic Rhinoplasty
- ☐ Brow Surgery
- ☐ Facial Surgery
- ☐ Gender Reassignment
- ☐ Laser Ablation
- ☐ Liposuction
- ☐ Neurovascular Flaps
- ☐ Other, please specify:

_____

_____

☐ **PSYCHIATRY**
- ☐ General

☐ **RADIOLOGY**
- ☐ Diagnostic Radiology
- ☐ Diagnostic Ultrasound

☐ **REHABILITATION MEDICINE**

☐ **SURGICAL ASSISTANT**

☐ **UROLOGY – GENERAL**
- ☐ Adult
- ☐ Paediatric (≥ 10 years)
- ☐ Laparoscopic Urology
- ☐ Laser
- ☐ Open Urological Procedures
- ☐ Brachytherapy
- ☐ HIFU
- ☐ Lithotripsy
- ☐ Other, please specify:

_____

_____

☐ **VASCULAR SURGERY**

Please specify:

_____

_____

Other Information:
Please provide specific information about the surgical procedures you plan on undertaking at the Burnside Hospital on a separate attachment.

4. QUALIFICATIONS *(Can be detailed in curriculum vitae and/or copies provided)*

Primary Degree:	**University / Organisation**	**Year obtained**
Postgraduate Degree(s):		
Postgraduate Diploma/Fellowship:		

5. OTHER TRAINING AND CLINICAL EXPERIENCE *(Can be detailed in curriculum vitae)*

With respect to your response to **Section 3**, please provide details of clinical experience and post-qualification training. Include the title of the course(s) undertaken, the organisation offering the course and the qualifications obtained.

6. CLINICAL APPOINTMENTS

a) Please provide details on all current and previous public and private clinical appointments during the past five years (including names of organisations and dates of appointment), or other places of practice (for example, general practice). ***(Can be detailed in curriculum vitae)***

Main appointment:	**Term of appointment**
Other appointments:	**Term of appointment**
b) Have you ever been denied a defined scope of clinical practice?	**YES | NO**
c) Has your right to practice ever been withdrawn, suspended, terminated or reduced?	**YES | NO**

If you answered **YES** to either question b) or c), please provide full details.

7. ACADEMIC APPOINTMENTS / TEACHING EXPERIENCE *(Can be detailed in curriculum vitae)*

Organisation	**Status / Level**	**Term of appointment**

8. RECENCY OF PRACTICE / PROFESSIONAL DEVELOPMENT / MEDICAL EDUCATION / ENGLISH LANGUAGE STANDARD

a) Over the last registration period have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory ***Recency of Practice Registration Standard***? If **NO**, please provide further information:	**YES | NO**
b) Over the last registration period have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory ***Continuing Professional Development Registration Standard***? If **NO**, please provide further information:	**YES | NO**
c) Have you satisfied the medical education/continuing professional development requirements of your college membership/fellowship? If **NO**, please provide further information:	**YES | NO**
d) Over the last registration period have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory ***English Language Skills Registration Standard***? If **NO**, please provide further information:	**YES | NO**

9. CLINICAL REVIEW/PEER REVIEW

Do you regularly participate in formal quality and peer review activities relevant to your scope of practice?	**YES | NO**
Please provide details of quality/peer review activities and or attachments:	

10. REGULATORY AND INDEMNITY INFORMATION

a) Registered health practitioners please provide your AHPRA registration number and expiry date: _____ Expiry date: _____/_____/_____	
b) Is this registration temporary? If **YES**, please provide details:	**YES | NO**

c) Do you have or have you ever had any conditions or restrictions placed on your registration. If **YES**, please provide full details.	**YES | NO**
d) Do you have a board appointed supervisor? If **YES**, please provide details (including name and location of supervisor and frequency of supervision.	**YES | NO**
e) Over the last registration period, have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory ***Professional Indemnity Insurance Registration Standard***? If **NO**, please provide further information:	**YES | NO**
f) Please provide the name of your medical defence organisation or your professional indemnity insurance provider and **provide a photocopy of your current membership certificate.**	
Name:	
Membership Number:	
Category of membership:	
Does your membership fully cover the scope of practice you have applied for?	**YES | NO**
g) Have there been or are there currently pending any claims, settlements, or judgements against you? If **YES**, please provide full details on a separate attachment.	**YES | NO**
h) Has your current or any previous medical defence organisation/professional indemnity insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage? If **YES**, please provide full details including the name of the relevant medical defence organisation/insurer.	**YES | NO**
i) Is your Provider Number subject to any restrictions? If **YES**, please provide details:	**YES | NO**

11. DISCLOSURE ABOUT DISCIPLINARY ACTIONS/CRIMINAL HISTORY

If you require further information to answer any questions, please attach separate pages identified with the relevant section number. You may also prefer to provide this information in a sealed envelope marked **"CONFIDENTIAL – FOR THE CHIEF EXECUTIVE OFFICER ONLY"** appended to this application.	
a) Have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory ***Criminal History Registration Standard***? If **NO**, please provide the details on a separate attachment.	**YES | NO**
b) Have you ever been the subject of disciplinary action in the course of your work as a registered practitioner? If **YES**, please provide details:	**YES | NO**

c) Have you ever been the subject of disciplinary action or professional sanctions imposed by any registration board within Australia or elsewhere? If **YES**, please provide details:	**YES | NO**
d) Have you ever been the subject of any investigation, inquiry or findings by any registration board in relation to your ability to practice or have direct patient contact or regarding your professional performance or your professional conduct? If **YES**, please provide details:	**YES | NO**
e) Have you ever had an adverse finding made against you that may be relevant to your appointment (in addition to anything you may have noted above)? If **YES**, please provide details on a separate attachment.	**YES | NO**

12. OPERATING LISTS, PROCEDURES, ITEM NUMBERS, INSTRUMENTATION OR SPECIALISED EQUPMENT AND/OR THE USE OF DISPOSABLE ITEMS

Please note that a request may be made for detailed information 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.

13. AFTER HOURS / EMERGENCY CARE PROVISIONS

Please provide details of a **registered/nominated practitioner from the same discipline** who is accredited at Burnside Hospital and who can be contacted for “back up” or “emergency” cover for your patients should the hospital be unable to contact you.

Name		
Professional address	***Postcode***	
Telephone	***B***	***M***

14. PHYSICIAN CONTACT

Please provide details of your 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 you are unable to provide details, please advise the Clinical Manager/After Hours Hospital Coordinator at the time of your patient’s admission.

Name		
Professional address	***Postcode***	
Telephone	***B***	***M***

15. REFEREES

Visiting Medical Officers/Specialists: Three (3) recent (within three years) referees who can comment on your requested Scope of Practice. For new applicants, referees must be from within your Speciality. For renewal applicants, at least two (2) must be from within your Speciality.
Surgical Assistants: Two (2) referees who can comment on your surgical assisting ability, at least one of whom must be a surgeon you will be /have been assisting.
Doctors-in-training and Career Medical Officers: Two (2) referees who can comment on your requested scope of practice and who have been in a supervisory capacity for at least eight (8) weeks.

Referee 1:		
Name		
Professional address	***Postcode***	
Telephone	***B***	***M***
Email		
Referee 2:		
Name		
Professional address	***Postcode***	
Telephone	***B***	***M***
Email		
Referee 3:		
Name		
Professional address	***Postcode***	
Telephone	***B***	***M***
Email		

16. AGREEMENT / UNDERTAKINGS

I understand that in assessing my application for appointment as a visiting medical/dental practitioner, the health service will make additional enquires as to my suitability for the position.

(Please circle)

a) I authorise the Burnside Hospital to obtain information relevant to my application from my current and any previous medical indemnity organisation.	**YES | NO**
b) I authorise the Burnside Hospital to obtain information relevant to my application from the Australian Health Practitioner Regulation Agency (AHPRA).	**YES | NO**
c) I authorise access to the information contained in this application by representatives of the Burnside Hospital's Clinical Privileges Advisory Committee.	**YES | NO**
d) If credentialed, I agree to familiarise myself with the Burnside War Memorial Hospital's Accredited Practitioner By-Laws, the hospital's Code of Conduct, relevant policies and procedures including but not limited to the hospital's emergency procedures and response codes.	**YES | NO**
e) If credentialed, I agree to abide by the Privacy Amendment (Enhanced Privacy Protection) Act 2012, Australian Privacy Principles and understand that any breaches may result in the cessation of my accreditation at the Burnside Hospital.	**YES | NO**

f)	I agree to notify the Chief Executive Officer of any event/situation which may impact on my ability to exercise my scope of clinical practice, whether it is due to medical registration matters or other matters including but not limited to criminal charges or convictions, reductions in registration or insurance.	**YES | NO**
g)	I agree to promptly notify the Burnside Hospital of any adverse finding made against me by any registration, disciplinary, investigative or professional body.	**YES | NO**
h)	If credentialed, I agree to work within my defined clinical privileges and to make a further application should I seek to extend or alter the clinical privileges granted to me.	**YES | NO**
i)	If credentialed, should any question as to my clinical privileges or clinical practice arise, I agree that the health service may make such inquiries as it considers necessary to assess whether the credentialing or my clinical privileges are appropriate.	**YES | NO**
j)	I agree to provide the Burnside Hospital with reasonable prior notice regarding planned absences, e.g. annual, conference, sick leave, to enable the Hospital to make suitable alternative arrangements in regards to theatre utilisation if required.	**YES | NO**

DECLARATION

I hereby declare that:

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

Signature: _____

Print Name: _____ **Date:** _____/_____/_____

AUTHORITY TO PROVIDE PROOF OF MEDICAL INDEMNITY COVER TO THE BURNSIDE HOSPITAL

It is a condition of your accreditation at the Burnside Hospital that you provide evidence of your current professional indemnity insurance. To facilitate this, you may wish to provide the Burnside Hospital with the authorisation to liaise directly with your insurer by completing the form below:

Name on Policy:	
Professional Indemnity Insurer: (i.e. MIGA, MDA; Avant; other)	
Professional Indemnity Membership Number:	
Professional Indemnity Policy Number:	
Professional Indemnity Insurance – Field of Practice:	

I authorise you to provide a copy of my professional indemnity insurance to the Burnside War Memorial Hospital on an annual basis.

Indefinitely or for the following period:	
Signature	
Date	

The Burnside War Memorial Hospital Inc.

120 Kensington Road, Toorak Gardens South Australia 5065

Tel: (08) 8202 7222 Fax: (08) 8364 0038 *www.burnsidehospital.asn.au*

Ref: Medical Board of Australia Mandatory Registration Standards:

- *Continuing Professional Development Registration Standard*
- *Criminal History Registration Standard*
- *English Language Skills Registration Standard*
- *Recency of Practice Registration Standard*
- *Professional Indemnity Insurance Registration Standard*