



## APPLICATION FOR CLINICAL PRIVILEGES

(Specialist Practitioner | 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](mailto: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 as it appears on certificates)		
Date of Birth		
Country of Birth		
Residency status: <ul style="list-style-type: none"> <li>• Australian Citizen</li> <li>• Permanent Resident of Australia</li> </ul>	YES / NO YES / NO If NO: _____	
Professional Address	<i>Postcode</i>	
Telephone:    B/H		
A/H   Mobile		
Facsimile:		
Email Address		
Postal Address (if different to Professional Address)	<i>Postcode</i>	
Private Address	<i>Postcode</i>	
Provider Number		
<b>REQUIRED ATTACHMENTS: Please attached the following documents to your application:</b>		
• Australian Health Practitioner Regulation Agency (AHPRA) Registration certificate	<input type="checkbox"/>	
• Curriculum vitae (CV) and academic certificates ( <i>New applications only</i> )	<input type="checkbox"/>	
• CPD Program Certificate of Compliance from Respective College ( <i>If applicable</i> )	<input type="checkbox"/>	

**Please turn overleaf**

<b>REQUIRED ATTACHMENTS: Please attached the following documents to your application:</b>	
• Criminal History Check and/or DCSI Screening Assessment ( <b>within three years</b> )	
○ National Police Certificate (NPC) from SAPOL or through an accredited Crimtrac Provider	<input type="checkbox"/>
○ Department for Communities and Social Inclusion (DCSI) child-related or other employment screening	<input type="checkbox"/>
○ Fit2Work Checks on behalf of AHPRA ( <i>Overseas applicants only</i> )	<input type="checkbox"/>
• Licence to Operate an Ionising Radiation Apparatus (EPA) ( <i>If applicable</i> )	<input type="checkbox"/>
• Medical Defence   Professional Indemnity Insurance Certificate	<input type="checkbox"/>
• Visa documents ( <i>If applicable</i> )	<input type="checkbox"/>

## 2. SPECIAL NOTES

<ul style="list-style-type: none"> <li>Applicants for Advanced Laparoscopic Surgery are required to provide details of experience, qualifications &amp; education verifying their competence with the equipment and the procedure. <b>Please attach relevant details to this application form.</b></li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>
<ul style="list-style-type: none"> <li>Paediatric patients: Burnside Hospital's admission exclusion criteria include paediatric patients less than 10 years of age.</li> </ul>

## 3. APPLICATION FOR CLINICAL PRIVILEGES

<b>a) Category</b>	<b>Specialist Practitioner</b> <input type="checkbox"/>
	<i>Specialist Title:</i>
	<b>General Practitioner (non-procedural)</b> <input type="checkbox"/>
	<b>Surgical Assistant</b> <input type="checkbox"/>

<b>b) Application for scope of practice</b>		
<p><input type="checkbox"/> <b>ANAESTHESIA</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Obstetric</li> <li><input type="checkbox"/> Paediatric (≥ 10 years as per Burnside Hospital admission exclusion criteria)</li> </ul> <p><input type="checkbox"/> <b>DENTAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> General Dentistry</li> <li><input type="checkbox"/> Special Needs Dentistry</li> </ul> <p><input type="checkbox"/> <b>DERMATOLOGY</b></p> <p><input type="checkbox"/> <b>ENT SURGERY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Paediatric (≥ 10 years)</li> <li><input type="checkbox"/> Adenoidectomy</li> <li><input type="checkbox"/> Bronchial Procedures</li> <li><input type="checkbox"/> Ear Procedures</li> <li><input type="checkbox"/> Facial Nerve</li> <li><input type="checkbox"/> Laryngeal Procedures</li> <li><input type="checkbox"/> Nasal Procedures</li> <li><input type="checkbox"/> Otolaryngology – Head &amp; Neck</li> <li><input type="checkbox"/> Pharyngeal Procedures</li> <li><input type="checkbox"/> Tonsillectomy</li> <li><input type="checkbox"/> Tracheal Procedures</li> <li><input type="checkbox"/> Other, please specify:</li> </ul> <hr/> <p><input type="checkbox"/> <b>GASTROENTEROLOGY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Upper Gastrointestinal Endoscopy</li> <li><input type="checkbox"/> Colonoscopy</li> <li><input type="checkbox"/> Percutaneous Endoscopic Gastrostomy (PEG)</li> <li><input type="checkbox"/> Other, please specify:</li> </ul> <hr/> <p><input type="checkbox"/> <b>GENERAL PRACTICE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Non-procedural</li> </ul>	<p><input type="checkbox"/> <b>GENERAL SURGERY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Upper Gastrointestinal Endoscopy</li> <li><input type="checkbox"/> Colonoscopy</li> <li><input type="checkbox"/> Percutaneous Endoscopic Gastrostomy (PEG)</li> <li><input type="checkbox"/> Bariatric                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Lap Banding</li> <li><input type="checkbox"/> Modified Roux-en-Y</li> <li><input type="checkbox"/> Sleeve Gastrectomy</li> <li><input type="checkbox"/> Other please specify:</li> </ul> </li> </ul> <hr/> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast Surgery</li> <li><input type="checkbox"/> Colorectal Surgery</li> <li><input type="checkbox"/> Endocrine Surgery                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Adrenalectomy</li> <li><input type="checkbox"/> Thyroidectomy</li> </ul> </li> <li><input type="checkbox"/> Gastrointestinal Surgery</li> <li><input type="checkbox"/> Hepatobiliary &amp; Pancreatic Surgery</li> <li><input type="checkbox"/> Laparoscopic Surgery</li> <li><input type="checkbox"/> Sentinel Node Biopsy</li> <li><input type="checkbox"/> Upper GI Surgery</li> </ul> <p><input type="checkbox"/> <b>GYNAECOLOGY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Advanced Laparoscopic Surgery</li> <li><input type="checkbox"/> Gynaecology General</li> <li><input type="checkbox"/> Ultrasound</li> <li><input type="checkbox"/> Gynaecological Oncology</li> <li><input type="checkbox"/> Uro-Gynaecology</li> </ul> <p><input type="checkbox"/> <b>INTENSIVE CARE MEDICINE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Paediatric (≥ 10 years)</li> </ul> <p><input type="checkbox"/> <b>INTERNAL MEDICINE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clinical Genetics</li> <li><input type="checkbox"/> Clinical Pharmacology</li> <li><input type="checkbox"/> Endocrinology</li> <li><input type="checkbox"/> Geriatric Medicine</li> <li><input type="checkbox"/> Haematology</li> <li><input type="checkbox"/> Hepatology</li> <li><input type="checkbox"/> Immunology and Allergy</li> <li><input type="checkbox"/> Infectious Diseases</li> <li><input type="checkbox"/> Medical Oncology</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Nephrology</li> <li><input type="checkbox"/> Neurology</li> <li><input type="checkbox"/> Respiratory Medicine                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Bronchoscopy-Diagnostic</li> <li><input type="checkbox"/> Bronchoscopy- Therapeutic</li> <li><input type="checkbox"/> Sleep Medicine</li> <li><input type="checkbox"/> Other please specify:</li> </ul> </li> </ul> <hr/> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rheumatology</li> <li><input type="checkbox"/> Other, please specify:</li> </ul> <hr/> <p><input type="checkbox"/> <b>OBSTETRICS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Maternal Fetal Medicine</li> <li><input type="checkbox"/> Obstetrics</li> <li><input type="checkbox"/> Ultrasound</li> </ul> <p><input type="checkbox"/> <b>OCCUPATIONAL AND ENVIRONMENTAL MEDICINE</b></p> <p><input type="checkbox"/> <b>OPHTHAMOLOGY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Paediatric (≥ 10 years)</li> <li><input type="checkbox"/> Cataract Surgery</li> <li><input type="checkbox"/> Corneal Transplantation</li> <li><input type="checkbox"/> Eyelid Surgery</li> <li><input type="checkbox"/> Glaucoma Surgery</li> <li><input type="checkbox"/> Lacrimal Surgery</li> <li><input type="checkbox"/> Oculoplastic</li> <li><input type="checkbox"/> Orbital Surgery</li> <li><input type="checkbox"/> Pterygium Surgery</li> <li><input type="checkbox"/> Refractive Surgery</li> <li><input type="checkbox"/> Squint Surgery</li> <li><input type="checkbox"/> Vitreoretinal Surgery</li> </ul> <p><input type="checkbox"/> <b>ORAL MAXILLOFACIAL SURGERY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Paediatric (≥ 10 years)</li> <li><input type="checkbox"/> Facio Maxillary Surgery</li> <li><input type="checkbox"/> Mandibular Osteotomy</li> <li><input type="checkbox"/> Other, please specify:</li> </ul>

<input type="checkbox"/> <b>ORTHOPAEDIC SURGERY</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric (≥ 10 years) <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Fracture Management <input type="checkbox"/> Major Joint Replacement <input type="checkbox"/> Reconstructive Surgery <input type="checkbox"/> Spinal Surgery  <input type="checkbox"/> <b>PAEDIATRIC MEDICINE</b> <input type="checkbox"/> General Medicine <input type="checkbox"/> Neonatology (Special care nursery for a Level 4 Hospital) (34 weeks gestation or later)  <input type="checkbox"/> <b>PAEDIATRIC SURGERY</b>  <input type="checkbox"/> <b>PAIN MEDICINE</b>  <input type="checkbox"/> <b>PALLIATIVE MEDICINE</b>  <input type="checkbox"/> <b>PATHOLOGY</b> <input type="checkbox"/> Anatomical/Cytopathology <input type="checkbox"/> Biochemistry <input type="checkbox"/> Chemical Pathology <input type="checkbox"/> General Pathology <input type="checkbox"/> Haematology <input type="checkbox"/> Immunology <input type="checkbox"/> Microbiology	<input type="checkbox"/> <b>PLASTIC AND RECONSTRUCTIVE SURGERY</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric (≥ 10 years) <input type="checkbox"/> Bat Ears <input type="checkbox"/> Repair of Lacerations <input type="checkbox"/> Revision of Scars <input type="checkbox"/> Abdominal Reductions <input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Cosmetic Rhinoplasty <input type="checkbox"/> Brow Surgery <input type="checkbox"/> Facial Surgery <input type="checkbox"/> Gender Reassignment <input type="checkbox"/> Laser Ablation <input type="checkbox"/> Liposuction <input type="checkbox"/> Neurovascular Flaps <input type="checkbox"/> Other, please specify:  <hr/> <input type="checkbox"/> <b>PSYCHIATRY</b> <input type="checkbox"/> General  <input type="checkbox"/> <b>RADIOLOGY</b> <input type="checkbox"/> Diagnostic Radiology <input type="checkbox"/> Diagnostic Ultrasound	<input type="checkbox"/> <b>REHABILITATION MEDICINE</b>  <input type="checkbox"/> <b>SURGICAL ASSISTANT</b>  <input type="checkbox"/> <b>UROLOGY – GENERAL</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric (≥ 10 years) <input type="checkbox"/> Laparoscopic Urology <input type="checkbox"/> Laser <input type="checkbox"/> Open Urological Procedures <input type="checkbox"/> Brachytherapy <input type="checkbox"/> HIFU <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Other, please specify:  <hr/> <hr/> <input type="checkbox"/> <b>VASCULAR SURGERY</b>  Please specify:  <hr/> <hr/>
<p><b>Other Information:</b>                  Please provide specific information about the surgical procedures you plan on undertaking at the Burnside Hospital on a separate attachment.</p>		

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

Primary Degree:	University / Organisation	Year obtained
<b>Postgraduate Degree(s):</b>		
<b>Postgraduate Diploma/Fellowship:</b>		

**5. OTHER TRAINING AND CLINICAL EXPERIENCE (Can be detailed in resume/CV)**

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 your CV)**

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

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

**7. ACADEMIC APPOINTMENTS / TEACHING EXPERIENCE (Can be detailed in your CV)**

Organisation	Status / Level	Term of appointment

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

<p>a) Over the last registration period have you satisfied the requirements of the Medical Board of Australia’s and AHPRA’s mandatory <b>Recency of Practice Registration Standard?</b> If <b>NO</b>, please provide further information.</p>	<p><b>YES   NO</b></p>
<p>b) Over the last registration period have you satisfied the requirements of the Medical Board of Australia’s and AHPRA’s mandatory <b>Continuing Professional Development Registration Standard?</b> If <b>NO</b>, please provide further information.</p>	<p><b>YES   NO</b></p>
<p>c) Have you satisfied the medical education/continuing professional development requirements of your college membership/fellowship? <b>Please attach a current CPD Program Certificate of Compliance.</b></p> <p>If <b>NO</b>, please provide further information.</p>	<p><b>YES   NO</b></p>
<p>d) Have you satisfied the requirements of the Medical Board of Australia’s and AHPRA’s <b>English Language Skills Registration Standard?</b> If <b>NO</b>, please provide further information.</p>	<p><b>YES   NO   N/A</b></p>

**9. CLINICAL REVIEW/PEER REVIEW**

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

**10. REGULATORY AND INDEMNITY INFORMATION**

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

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

## 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 <b>"CONFIDENTIAL – FOR THE CHIEF EXECUTIVE OFFICER ONLY"</b> appended to this application.	
a) Have you satisfied the requirements of the Medical Board of Australia's and AHPRA's mandatory <b>Criminal History Registration Standard</b> ? If <b>NO</b> , please provide the details on a separate attachment.	<b>YES   NO</b>
b) Have you ever been the subject of disciplinary action in the course of your work as a registered practitioner? If <b>YES</b> , please provide details:	<b>YES   NO</b>

c) Have you ever been the subject of disciplinary action or professional sanctions imposed by any registration board within Australia or elsewhere? If <b>YES</b> , please provide details:	<b>YES   NO</b>
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 <b>YES</b> , please provide details:	<b>YES   NO</b>
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 <b>YES</b> , please provide details on a separate attachment.	<b>YES   NO</b>

## 12. OPERATING LISTS, PROCEDURES, ITEM NUMBERS, INSTRUMENTATION OR SPECIALISED EQUIPMENT 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.

<b>Name</b>		
<b>Professional address</b>	<b>Postcode</b>	
<b>Telephone</b>	<b>B</b>	<b>M</b>

## 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.

<b>Name</b>		
<b>Professional address</b>	<b>Postcode</b>	
<b>Telephone</b>	<b>B</b>	<b>M</b>



**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.

<b>Referee 1:</b>		
<b>Name</b>		
<b>Professional address</b>		
	<b>Postcode</b>	
<b>Telephone</b>	<b>B</b>	<b>M</b>
<b>Email</b>		
<b>Referee 2:</b>		
<b>Name</b>		
<b>Professional address</b>		
	<b>Postcode</b>	
<b>Telephone</b>	<b>B</b>	<b>M</b>
<b>Email</b>		
<b>Referee 3:</b>		
<b>Name</b>		
<b>Professional address</b>		
	<b>Postcode</b>	
<b>Telephone</b>	<b>B</b>	<b>M</b>
<b>Email</b>		

**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.	<b>YES   NO</b>
b) I authorise the Burnside Hospital to obtain information relevant to my application from the Australian Health Practitioner Regulation Agency (AHPRA).	<b>YES   NO</b>
c) I authorise access to the information contained in this application by representatives of the Burnside Hospital's Clinical Privileges Advisory Committee.	<b>YES   NO</b>
d) If credentialed, I agree to abide by 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. A copy of the Accredited Practitioner By-Laws can be obtained from: <a href="https://www.burnsidehospital.asn.au/health-professionals/information/become-a-specialist-at-burnside-hospital/">https://www.burnsidehospital.asn.au/health-professionals/information/become-a-specialist-at-burnside-hospital/</a>	<b>YES   NO</b>

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 notify promptly 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**

<p>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:</p>	
<p><i>Name on Policy:</i></p> <p><i>Professional Indemnity Insurer: (i.e. MIGA, MDA; Avant; other)</i></p> <p><i>Professional Indemnity Membership Number:</i></p> <p><i>Professional Indemnity Policy Number:</i></p> <p><i>Professional Indemnity Insurance – Field of Practice:</i></p>	
<p><i>I authorise you to provide a copy of my professional indemnity insurance to the Burnside War Memorial Hospital on an annual basis.</i></p>	
<p><i>Indefinitely or for the following period:</i></p> <p><b>Signature</b></p> <p><b>Date</b></p>	

**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](http://www.burnsidehospital.asn.au)

Ref: Medical Board of Australia Registration Standards:

1. Continuing Professional Development Registration Standard
2. Recency of Practice Registration Standard
3. English Language Skills Registration Standard
4. Professional Indemnity Insurance Registration Standard
5. Criminal History Registration Standard