HOSPITAL BY-LAWS ANNEXURES

Commercial in confidence

Table of Contents

ANNEXURE A1 APPLICATION FOR ACCREDITATION – MEDICAL PRACTITIONER OR DENTIST (INCLUDING SURGICAL ASSISTANT - MEDICAL) AT [INSERT FACILITY NAME]

Application for Accreditation as a Medical Practitioner (including Surgical Assistant – Medical) or Dentist

Please submit your completed application form with the documentation requested in the sections following to the Chief Executive Officer at UNITAS SUNSHINE PRIVATE HOSPITAL

❑ **New Appointment** ❑ **Reappointment**

For Reappointment:

If this is an application for reappointment and there are no changes to the information required in this application you will only be required to tick the box below, sign and complete your contact details on this application.

❑ This is an application for my reappointment and there are no changes to the information required in the Application for Accreditation since I last applied at UNITAS SUNSHINE PRIVATE HOSPITAL

_____ _____

Signature of Medical Practitioner *Date*

Section 1: Personal Details

Title: *(A/Prof, Dr, Mr, Prof)*	
Surname of Applicant:	
First Names in full:	
Any Former Name Including Maiden Name:	
Date of birth:	
Accreditation category: *(Please refer to page 3 for the criteria category)*	
Partner / Spouse Full Name: *(optional - for invitation purposes only)*	
Provider Number:	
Prescriber Number:	
Emergency Contact Name:	
Emergency Contact Number:	

Personal Address Details

Please tick ☑ your preferred mailing address that is Personal or Practice or Other:

❑ Residential Address:	

Suburb:		Post Code:	
Home Phone Number:		Home Facsimile:	
Mobile Number:			
Email:			

Practice Address Details (primary):

❑ Practice Address			
Suburb:		Post Code:	
Practice Telephone:		Practice Facsimile:	
Pager Telephone:		Pager Number:	
Mobile Number:			
Email Address:			

Other Address (other consulting rooms etc):

❑ Other Address

Section 2 Qualifications (*Please attach your Curriculum Vitae and Qualification Documents)*

Undergraduate qualifications, university and year of graduation:

Year Obtained:	Qualification:	Institution:

Postgraduate qualifications, degrees, diplomas, fellowship: *Note: Certified copies of original qualifications should be obtained, if possible*

Year obtained:	Qualification:	Authorising Body:

Special comments on post graduate experience:

Year obtained:	Qualification:	Authorising Body:

Special comments on post graduate experience:

Year obtained:	Qualification:	Authorising Body:
Special comments on post graduate experience:		

Section 3 Appointments:		
Current Appointments:		
Dates:	**Facility:**	**Appointments:**
Previous Appointments (last ten years):		
Dates (From / To):	**Facility:**	**Appointments:**
Itemise Postgraduate Educational Activity in the past three years:		
➢ ➢ ➢ ➢		
Nature of current practice and place of work		
Publications *(Please attach list or CV): Attached?*	Yes ❒	No ❒
Membership of colleges and/or other relevant Associations *(Please attach list or CV):*	Yes ❒	No ❒

Section 4 Accreditation, Scope of Practice

Accreditation is sought in the following categories:

- ❑ Career / Contracted Medical Officer
- ❑ Consultant Emeritus *(No admitting rights)*
- ❑ Consultant Specialist/General Practitioner *(No admitting rights)*
- ❑ Dental Specialist
- ❑ Dentist
- ❑ General Practitioner
- ❑ Employed Medical Officer *(Resident, Registrar, Career Medical Officer)*
- ❑ Specialist Practitioner
- ❑ Staff Specialist
- ❑ Surgical Assistant *(No admitting rights)*

Accreditation is sought to:

- ❑ Admit
- ❑ Consult
- ❑ Diagnostic / Treat
- ❑ Assist

Specialty In Which Accreditation Is Applied For:

Please complete Scope of Practice (page 3) to complete your Specialty (n/a Surgical Assistants)

Does your scope of practice require the use of:

1) Fluoroscopy / Laser and / or Angiography Equipment	❑ Yes ❑ No
If Yes *attach the EPA Radiation Licence to this application and note the Radiation User Licence Expiry Date* ☞	
2) Laser Equipment	❑ Yes ❑ No
If Yes *attach the Laser Certification to this application and note the Laser Certificate Expiry Date* ☞	

Appointment Period (to be completed by the hospital)

❑ Temporary ❑ Five Years ❑ Other Term	------ / ----- / 20-- to ----- / ----- / 20--

Surgical Assistant applicants only: Name of accredited practitioner at Unitas Sunshine Private Hospital who will provide a reference for you.		
Name	**Address & Phone Number**	**Hospital**
Name	**Address & Phone**	**Hospital**
Name	**Address & Phone**	**Hospital**
Name	**Address & Phone**	**Hospital**
Name	**Address & Phone**	**Hospital**
Accreditation (Please tick):		
❑ Permanent	❑ Temporary from _____/_____/ 20____ to _____/_____/ 20____	

Clinical privileges are sought in the field(s) of: *(Not applicable to Surgical Assistants)*

- ❑ **Anaesthesia**
  - ❑ Adults
  - ❑ Cardiac-Adult Only
  - ❑ Neonatal (<1 year old)
  - ❑ Obstetrics
  - ❑ Paediatrics (>1 year old)
  - ❑ Trans-oesophageal Echocardiography (TOE)-Adults Only
  - ❑ Chronic Pain
- ❑ **Cardiology**
  - ❑ Medical Cardiology
  - ❑ TOE
- ❑ **Emergency Medicine**
- ❑ **Gastroenterology**
  - ❑ Diagnostic Upper Gastrointestinal Endoscopy
  - ❑ Therapeutic Upper Gastrointestinal Endoscopy
  - ❑ Sclerotherapy
  - ❑ Oesophageal Banding & Placement of Prostheses
  - ❑ Oesophageal Dilatation
  - ❑ Flexible Sigmoidoscopy
  - ❑ Diagnostic Colonoscopy
  - ❑ Endoscopic Retrograde Cholangiopancreatography (ERCP) & associated Therapeutic Interventions
  - ❑ Biliary Stenting
  - ❑ Percutaneous Gastrostomy (PEG)
- ❑ **Gynaecology-General**
  - ❑ Advanced Endoscopic Surgery
  - ❑ Gynaecology General
  - ❑ Laparoscopic Surgery
  - ❑ Prolapse Surgery
  - ❑ Ultrasound
  - ❑ Assisted Reproductive Services
  - ❑ Gynaecological Oncology
  - ❑ Gynaecology Oncology
  - ❑ Uro-Gynaecology
- ❑ **Intensive Care**
  - ❑ Adult
  - ❑ Paediatric

Medicine

- ❑ **General Medicine**
  - ❑ Adult
  - ❑ Paediatric Medicine
    - ❑ General Medicine
    - ❑ Neonatology (34 weeks or later)
  - ❑ Medical Oncology
  - ❑ Dermatology
  - ❑ Endocrinology
  - ❑ Geriatrics
  - ❑ Hepatology
  - ❑ Immunology
  - ❑ Infectious Diseases
  - ❑ Internal Medicine
  - ❑ Neurology
  - ❑ Oncology
    - ❑ Adult
    - ❑ Medical Oncology
    - ❑ Paediatric Oncology
  - ❑ Palliative Care
  - ❑ Haematology
  - ❑ Rehabilitation
  - ❑ Renal Medicine
    - ❑ Nephrology-General
    - ❑ Nephrology-Interventional
    - ❑ Renal Dialysis
  - ❑ Respiratory Medicine
    - ❑ Bronchoscopy-Diagnostic
    - ❑ Bronchoscopy-Therapeutic
    - ❑ Sleep Medicine
  - ❑ Rheumatology
  - ❑ Other please specify:

- ❑ **Occupational Medicine**
- ❑ **Pathology**
- ❑ **Psychiatry**
  - ❑ General Adult
  - ❑ Consultation - Liaison
  - ❑ Addiction Psychology
  - ❑ PTSD (EMDR)
  - ❑ ECT
  - ❑ TMS
  - ❑ Eating Disorder
  - ❑ Psychotherapy
- ❑ **Radiology**
  - ❑ Diagnostic Imaging
  - ❑ Interventional Radiology

Surgery

- ❑ **Dental**
  - ❑ Adult
  - ❑ Paediatric
- ❑ **Dental Specialist**
  - ❑ Specify:

- ❑ **ENT Surgery**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Paediatric Endoscopic
  - ❑ Adenoidectomy
  - ❑ Bronchial Procedures
  - ❑ Ear Procedures
  - ❑ Facial Nerve
  - ❑ Laryngeal Procedures
  - ❑ Otolaryngeal-Head& Neck
  - ❑ Pharyngeal Procedures
  - ❑ Tonsillectomy
  - ❑ Tracheal Procedures
  - ❑ Other please specify:

- ❑ **General Surgery**
  - ❑ Adult
  - ❑ Colorectal Surgery
  - ❑ Endocrine Surgery
    - ❑ Adrenalectomy
    - ❑ Thyroidectomy
  - ❑ Endoscopic Surgery
  - ❑ Gastrointestinal Surgery
  - ❑ Laparoscopic Surgery
    - ❑ Diagnostic
    - ❑ Interventional
  - ❑ Upper GI Surgery

- ❑ **General Surgery – sub specialty**
  - ❑ Paediatric
  - ❑ Breast Surgery
    - ❑ Oncoplastic
  - ❑ Hepatobiliary & Pancreatic Surgery
  - ❑ Oesophagectomy
  - ❑ Bariatric – Adults & (16-18yo) only
    - ❑ Lap Banding
    - ❑ Modified Roux-en-Y
    - ❑ Sleeve Gastrectomy
- ❑ **Neurosurgery**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Nerve Procedures
  - ❑ Spinal Procedures

- ❑ **Ophthalmology**
  - ❑ Adult
  - ❑ Paediatric
  - ❑ Cataract Surgery
  - ❑ Corneal transplantation
  - ❑ Eyelid Surgery
  - ❑ Glaucoma Surgery
  - ❑ Lacrimal Surgery

- ❑ Oculoplastic
- ❑ Orbital Surgery
- ❑ Pterygium Surgery
- ❑ Refractive Surgery
- ❑ Squint Surgery

❑ **Oral and Maxillofacial Surgery**
- ❑ Adult
- ❑ Paediatric
- ❑ Facio-Maxillary Surgery
- ❑ Mandibular Osteotomy
- ❑ Other please specify:

❑ **Orthopaedics - General**
- ❑ Adult
- ❑ Paediatric
- ❑ Arthroscopy
- ❑ Fracture Management
- ❑ Major Joint Replacement
- ❑ Foot and Ankle

❑ **Orthopaedics – sub specialty**
- ❑ Reconstructive Surgery
- ❑ Spinal Surgery

❑ **Paediatric Surgery**
- ❑ Other please specify:

❑ **Plastic and Reconstructive Surgery**
- ❑ Adult
- ❑ Cosmetic Surgery
  - ❑ Augmentation Mammoplasty
  - ❑ Abdominoplasty
  - ❑ Blepharoplasty
  - ❑ Body Contouring
  - ❑ Body Lift
  - ❑ Brachioplasty
  - ❑ Brow Lift
  - ❑ Laser Ablation
  - ❑ Liposuction
  - ❑ Mastopexy
  - ❑ Mentoplasty
  - ❑ Otoplasty
  - ❑ Rhinoplasty
  - ❑ Rhytidectomy
- ❑ Reconstructive Surgery
  - ❑ Breast reconstructive surgery
  - ❑ Burns Surgery
  - ❑ Facial Reconstruction
  - ❑ Hand Surgery
  - ❑ Microsurgery
  - ❑ Neurovascular Flaps
  - ❑ Surgery for congenital deformity
- ❑ Paediatric
  - ❑ Bats Ears Only
  - ❑ Repair Lacerations Only
  - ❑ Revision of Scars Only
- ❑ Other please specify

❑ **Podiatric Surgery**
- ❑ Adult
- ❑ Paediatric
- ❑ Podiatric procedures
- ❑ Foot nail surgery
- ❑ Skin and Soft Tissue Surgery of the foot and ankle
- ❑ Excision of ganglionic cysts and other soft tissue masses and/or neoplasms
- ❑ Fasciotomy/-ectomy of foot and ankle structure
- ❑ Repair/Lengthening/Transposition/Tenotomy of tendons foot and ankle (including Achilles Tendon repair)
- ❑ Neurectomy of terminal nerve structures of the foot and ankle for neural disorders
- ❑ Bone graft harvest from bone of foot/distal tibia/fibula
- ❑ Insertion of hardware, including internal and percutaneous fixation, bone graft, orthobiologics and implants for procedures of the foot and ankle (partial)
- ❑ Hardware removal from the foot and ankle
- ❑ Osteotomy of the 1st metatarsal for the treatment of conditions such as Hallux Valgus, Hallux Rigidus or other acquired deformity
- ❑ Lesser digital surgery, including Arthroplasty or Arthrodesis for the treatment of digital deformity
- ❑ Osteectomy/exostectomy to foot and ankle structure
- ❑ Osteotomy of isolated or multiple bones of the foot as primary or adjunct procedure for the treatment of foot and ankle deformity
- ❑ Isolated or Multiple Midfoot and/or Rearfoot Arthrodesis
  Isolated Ankle Arthrodesis
  Ankle Arthroplasty (Osteectomy or osteochondral lesion of the talus excluding total ankle implant arthroplasty)
- ❑ Other please specify:

❑ **Urology - General**
- ❑ Adult
- ❑ Paediatric
- ❑ Endoscopic Urology
- ❑ Laparoscopic Urology
- ❑ Laser
- ❑ Green Light Laser
- ❑ Open Urological Procedures
- ❑ Other please specify

❑ **Urology – Sub Specialty**
- ❑ HiFU
- ❑ Lithotripsy

❑ **Vascular Surgery**
❑ Procedure:
- ❑ Anastomosis
- ❑ Arterial Patch
- ❑ Bypass
- ❑ Decompression
- ❑ Enbolectomy
- ❑ Endarterectomy
- ❑ Ligation of Aneurysms
- ❑ Repair
- ❑ Replacement
- ❑ Thrombectomy
- ❑ Vascular Trauma of the following:
  - ❑ Adnominal
  - ❑ Aortic
  - ❑ Mesenteric
  - ❑ Open
- ❑ Axillary, Subclavian
- ❑ Other please specify

Other privileges sought: ***(Not applicable to surgical assistants)***				
Field	Surgical Admitting	Medical Admitting	Consulting	Other (specify)

Section 5 Referees

For each speciality in which you are seeking privileges, please provide the names, addresses and contact numbers of three peer referees in Australia who can attest to your recent practice and who are not related to you nor financially linked with or financially dependent on you. ***(Not applicable to surgical assistants)***

Name of Referee 1:			
Specialty:			
Address:			
Contact Number:		Email:	
Name of Referee 2:			
Specialty:			
Address:			
Contact Number:		Email:	
Name of Referee 3:			
Specialty:			
Address:			
Contact Number:		Email:	

Section 6 Registration

Please record your current AHPRA registration number and attach a photocopy of you registration certificate to the application:

State(s):		Registration Number:		Expiry Date:	
Scope of Clinical Practice:					
6.1 Do you have any endorsements or notations against your current medical registration? *(circle)*				Yes ❒	No ❒
If Yes provide details:					

6.2 Do you have any conditions, undertakings or reprimands against your current medical registration? *(circle)*	Yes ❒	No ❒
If Yes, provide details:		
6.3 As per Unitas Sunshine Private Hospital By-Laws should AHPRA impose any conditions and/or restrictions on my medical registration or should I enter into an agreement with AHPRA about these matters, in the future, I confirm that I will immediately notify the Hospital's CEO of the nature and extent of such conditions and/or restrictions.	Yes ❒	No ❒

Section 7 Insurance and Disclosure

Please state the name of your Medical Defence Organisation or your Professional Indemnity Insurance Provider and attach a copy of your current Professional Indemnity Insurance Certificate and Schedule to this application.

NB: Accredited Practitioners must hold professional indemnity insurance cover issued by an Australian insurer. All Accredited Practitioners must hold a minimum level of cover of $20 million for each claim and in the aggregate.

Where the Accredited Practitioner will be conducting Clinical Trials or Research this needs to be noted on the policy.

Please note it is a requirement to provide a copy yearly upon policy renewal to the Hospital CEO as documentary evidence of the level of this cover and also to immediately advise any material changes to the level of cover or conditions of the policy.

Name on Policy:		Expiry Date:	/ /20
Policy Number:		Insurance Company:	
Category of cover: *(insert specialty e.g. Surgeon – General):*			
Billing less than $ *(insert amount) (insert specialty)*			

7.1. Does your insurance fully cover the types of privileges you have applied for?	Yes ❒	No ❒
7.2. Do you have any conditions imposed by your indemnity insurance provider that you are required to comply with in order to maintain coverage or are there limitations on coverage ? (If so, please provide a copy of the relevant section of your insurance policy)	Yes ❒	No ❒
7.3. I consent to Unitas Sunshine Private Hospital contacting my indemnity insurance provider directly, should it desire for any reason, to obtain a full copy of my indemnity insurance policy. *(If yes, please provide the attached signed authority)*	Yes ❒	No ❒
7.4. Should my indemnity insurance provider impose any conditions and/or restrictions on my Indemnity insurance policy, in the future, I confirm that I will immediately notify the hospital CEO of the nature and extent of such conditions and/or restrictions.	Yes ❒	No ❒
7.5. Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been the subject of internal or external review, reduced, suspended or revoked or have you had conditions attached to that appointment for any reason?	Yes ❒	No ❒
If you answered Yes to the above, please provide dates and particulars:		
7.6. Have you ever had any restrictions / conditions placed on your Medical Registration or have you ever entered into undertakings with AHPRA or your registration board ?	Yes ❒	No ❒
(If you answered Yes to the above, please provide details including details of the restrictions / conditions and period during which the restrictions apply / applied):		

7.7 Have you previously been refused accreditation at another health care facility?	Yes ❒	No ❒
(If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note: A senior executive of the hospital may contact the facility)		
7.8 Has your Scope of Practice or Clinical Privileges been restricted, suspended, not renewed or have you been the subject of adverse or critical findings as part of an internal or external review initiated at any other health care facility?	Yes ❒	No ❒
(If you answered yes to the above, please provide name of the facility & rationale for refusal / restriction / suspension / recommendation. Please note, a senior executive of the hospital may contact the facility).		
7.9 Are you currently under investigation or have there ever been any adverse or critical findings made against you which may be relevant to your appointment (for example: with respect to patient management, behaviour, breach of insurance / medical laws, professional misconduct, sexual assaults or assault) by: Health Insurance Commission / Medicare / Professional Services Review, Medical Board / AHPRA, a Health Care Complaints Commission/body, a Coroner, Police, College, a Court or any other professional disciplinary or similar body?	Yes ❒	No ❒
(If you answered yes to the above, please provide details)		
7.10 Do have any illness or disability which may adversely affect your ability or fitness to practice?	Yes ❒	No ❒
(If you answered yes to the above, please provide details)		
7.11 Criminal Record Check – have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence, any offence involving dishonesty or drugs, breach of any laws that regulate the provision of health care or health insurance, charged with or convicted of a criminal indictable offence (other than a spent conviction)?	Yes ❒	No ❒
(If you answered yes to the above, please provide details and a copy of your current police check last three (3) months)		
7.12 Working with Children – complete if applicable A Working with Children Check is required of applicants who will be undertaking direct and unsupervised contact with children in the course of their work.	WWCC Clearance Number:	
7.13 Are you likely to be undertaking child related work meeting the definition above?	Yes ❒	No ❒

7.14 If you answered yes to the above question, do you consent to make a prohibited Employment Declaration and a Background Check, as prescribed by the relevant law?	Yes ❒	No ❒

Please attach your current Working With Children Clearance Certificate to this application

Section 8 Emergency Contact

Please nominate a medical practitioner accredited at the Unitas Sunshine Private Hospital with an equivalent scope of practice where you are seeking accreditation who has agreed to be contacted and deputise for you in the event that you are unavailable. *(NB: Not applicable for Surgical Assistants):*

Name:			
Specialty:			
Contact Numbers:	Home:	Mob:	Pager:
Facility:			

Specialist Directory: *(Not applicable to surgical assistants)*

• I authorise the Hospital to include my details in the Hospitals Specialist Directory	**Yes** ❒	**No** ❒

Authority:

- I hereby apply for accreditation at *UNITAS SUNSHINE PRIVATE HOSPITAL* for the clinical privileges I have specified and as attached to this application.
- In making this application I acknowledge and agree that:
  - ❖ I have received a copy of the Somewhere Hospital By-Laws.
  - ❖ I have read and understood the Somewhere Hospital By-Laws.
  - ❖ If I am appointed I accept all of requirements set out in, and will comply in full with, the Somewhere By-Laws, as amended from time to time.
  - ❖ The Hospital executives, its officers and the medical advisory committee may seek information about my past experience, clinical performance and current fitness.
  - ❖ If I have provided misleading, deceptive or inaccurate information or information which is likely to mislead, deceive or be inaccurate (including through omission), Somewhere may (in its absolute discretion) immediate proceed to suspension or termination of my Accreditation.
  - ❖ I will immediately notify the CEO of UNITAS SUNSHINE PRIVATE HOSPITAL of any material changes or additional relevant information with respect to the information already provided by me in connection with this application so that it remains accurate while the application is under consideration.
  - ❖ I will also notify the CEO in any of the following events (but not limited to the following events):
    - ❖ The relevant statutory professional registration board makes an adverse finding against me or suspends, revokes or places any limitation on my registration;
    - ❖ I do not have professional indemnity insurance cover in place for any reason;
    - ❖ I am convicted of a serious criminal offence
  - ❖ I understand that my Appointment as an Accredited Practitioner, if granted, will be reviewed in 5 years or earlier if considered necessary.

Applicant's Name:			
Signature		**Date:**	
Witness Name:			
Signature:		**Date:**	

ANNEXURE A2 APPLICATION FOR ACCREDITATION OF HEALTH PROFESSIONAL (OTHER THAN MEDICAL PRACTITIONER OR DENTIST)

Application for Accreditation of Health Professional (Other than Medical Practitioner or Dentist)

Please submit your completed application form with the documentation requested in the sections following to the Chief Executive Officer at UNITAS SUNSHINE PRIVATE HOSPITAL

❑ **New Appointment** ❑ **Reappointment**

For Reappointment:

If this is an application for reappointment and there are no changes to the information required in this application you will only be required to tick the box below, sign and complete your contact details on this application.

❑ This is an application for my reappointment and there are no changes to the information required in the Application for Accreditation since I last applied at [INSERT FACILITY NAME/S]

_____ _____

Signature of Health Professional *Date*

Section 1: Personal Details

Title:	
Surname of Applicant:	
First Names in full:	
Any Former Name Including Maiden Name:	
Date of birth:	
Accreditation category: *(Please refer to page 3 for the criteria category)*	
Provider Number *(if applicable)*:	
Prescriber Number *(if applicable)*	
Emergency Contact Name:	
Emergency Contact Number:	

Personal Address Details			
Please tick ☑ your preferred mailing address that is Personal or Practice or Other:			
❑ Residential Address:			
Suburb:		Post Code:	
Home Phone Number:	Home Facsimile:		
Mobile Number:			
Email:			
Practice Address Details (primary) if applicable:			
❑ Practice Address			
Suburb:		Post Code:	
Practice Telephone:	Practice Facsimile:		
Pager Telephone:	Pager Number:		
Mobile Number:			
Email Address:			
Other Address (other consulting rooms etc) if applicable:			
❑ Other Address			

Section 2 Qualifications (*Please attach your Curriculum Vitae and Qualification Documents)*

Undergraduate qualifications, university and year of graduation:

Year Obtained:	Qualification:	Institution:

Postgraduate qualifications, degrees, diplomas, fellowship: *Note: Certified copies of original qualifications should be obtained, if possible*

Year obtained:	Qualification:	Authorising Body:

Special comments on post graduate experience:

Year obtained:	Qualification:	Authorising Body:

Special comments on post graduate experience:		
Year obtained:	**Qualification:**	**Authorising Body:**
Special comments on post graduate experience:		

Section 3 Appointments:

Current Appointments:

Dates:	Facility:	Appointments:

Previous Appointments / Employment History (last ten years):

Dates (From / To):	Facility:	Appointments:

Itemise Postgraduate Educational Activity in the past three years:

-
-
-
-

Nature of current practice and place of work

Publications *(Please attach list or CV if applicable): Attached?*	Yes ❒	No ❒
Membership of colleges and/or other relevant Associations *(Please attach list or CV):*	Yes ❒	No ❒

Appointment Period (to be completed by the hospital)

❑ Temporary ❑ Five Years ❑ Other Term ------ / ----- / 20-- to ----- / ----- / 20—	❑ Employed ❑ Full Time ❑ Part Time ❑ Casual

Section 4 Accreditation, Scope of Practice

Appointment / employment (as relevant) sought:

❒ Allied Health Professional	❒ Chiropractor	❒ Occupational Therapist
❒ Physiotherapist	❒ Podiatrist	❒ Psychologist
❒ Speech Therapist	❒ Social Worker	
❒ Other: *(please specify)*		

❒ Nurse Practitioner (*Please provide details):*
❒ Perioperative Nurse Surgical Assistant (*Please provide details):*
❒ Registered Nurse employed by credentialed Visiting Medical Officer (*Please provide details: including evidence of VMO insurance covering your practice)*
❒ Other Practitioner (*Please provide details):*
Name of accredited practitioner at the hospital who is sponsoring you and with whom you will work? (complete if applicable for the clinical privileges sought)

Section 5 Referees

Please provide the names, addresses and contact numbers of three peer referees in Australia who can attest to your recent practice and who are not related to you nor financially linked with or financially dependent on you.

Name of Referee 1:			
Specialty:			
Address:			
Contact Number:		Email:	
Name of Referee 2:			
Specialty:			

Address:			
Contact Number:		Email:	
Name of Referee 3:			
Specialty:			
Address:			
Contact Number:		Email:	

Section 6 Registration

Please record your current AHPRA registration number and attach a photocopy of your registration certificate to the application:

State(s):		Registration Number:		Expiry Date:	/ /20
Scope of Clinical Practice:					
6.1 Do you have any endorsements or notations against your current medical registration? *(circle)*				Yes ❒	No ❒
If Yes provide details:					
6.2 Do you have any conditions, undertakings or reprimands against your current health practitioner registration? *(circle)*				Yes ❒	No ❒
If Yes, provide details:					
6.3 As per Unitas Sunshine Private Hospital By-Laws should AHPRA impose any conditions and/or restrictions on my medical registration, in the future, I confirm that I will immediately notify the Hospital's CEO of the nature and extent of such conditions and/or restrictions.				Yes ❒	No ❒

Section 7 Insurance and Disclosure

Complete all sections if your engagement is as an independent contractor. Complete sections 7.5 to 7.14 if your engagement is as an employee of Unitas Sunshine Private Hospital.

Please state the name of your Medical Defence Organisation or your Professional Indemnity Insurance Provider and attach a copy of your current Professional Indemnity Insurance Certificate and Schedule to this application.

NB: Accredited Practitioners must hold professional indemnity insurance cover issued by an Australian insurer. All Accredited Practitioners must hold a minimum level of cover of $20 million for each claim and in the aggregate.

Please note it is a requirement to provide a copy yearly upon policy renewal to the Hospital CEO as documentary evidence of the level of this cover and also to immediately advise any material changes to the level of cover or conditions of the policy.

Name on Policy:		Expiry Date:	/ /20
Policy Number:		Insurance Company:	
Category of cover: *(insert specialty e.g. Physiotherapist, Nurse Practitioner-Cardiology)*			

7.1. Does your insurance fully cover the types of privileges you have applied for?	Yes ❒	No ❒
7.2. Do you have any conditions imposed by your indemnity insurance provider that you are required to comply with in order to maintain coverage? (If so, please provide a copy of the relevant section of your insurance policy)	Yes ❒	No ❒
7.3. I consent to Unitas Sunshine Private Hospital contacting my indemnity insurance provider directly, should it desire for any reason, to obtain a full copy of my indemnity insurance policy. *(If yes, please provide the attached signed authority)*	Yes ❒	No ❒
7.4. Should my indemnity insurance provider impose any conditions and/or restrictions on my Indemnity insurance policy, in the future, I confirm that I will immediately notify the hospital CEO of the nature and extent of such conditions and/or restrictions.	Yes ❒	No ❒
7.5. Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked or have you had conditions attached to that appointment for any reason?	Yes ❒	No ❒
If you answered Yes to the above, please provide dates and particulars:		
7.6. Have you ever had any restrictions / conditions placed on your Health Practitioner Registration?	Yes ❒	No ❒
(If you answered Yes to the above, please provide details including details of the restrictions / conditions and period during which the restrictions apply / applied):		
7.7 Have you previously been refused credentialing at another health care facility?	Yes ❒	No ❒
(If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note: A senior executive of the hospital may contact the facility)		
7.8 Has your Scope of Practice been restricted, suspended, not renewed or had any written recommendations made against your accreditation at any other health care facility?	Yes ❒	No ❒
(If you answered yes to the above, please provide name of the facility & rationale for refusal / restriction / suspension / recommendation. Please note, a senior executive of the hospital may contact the facility).		
7.9 Are you currently under investigation or have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance / health practitioner laws, professional misconduct, sexual assaults or assault) by: The Health Insurance Commission, an Allied Health or Nursing Board, a Health Care Complaints Commission/body, a Coroner, a Court or any other professional disciplinary or similar body?	Yes ❒	No ❒
(If you answered yes to the above, please provide details)		

7.10 Do have any illness or disability which may adversely affect your fitness to practice?	Yes ❒	No ❒
(If you answered yes to the above, please provide details)		
7.11 Criminal Record Check – have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence, any offence involving dishonesty or drugs, breach of any laws that regulate the provision of health care or health insurance, charged with or convicted of a criminal indictable offence (other than a spent conviction)?	Yes ❒	No ❒
(If you answered yes to the above, please provide details and a copy of your current police check last three (3) months)		
7.12 Working with Children – complete if applicable A Working with Children Check is required of applicants who will be undertaking direct and unsupervised contact with children in the course of their work.	WWCC Clearance Number:	
7.13 Are you likely to be undertaking child related work meeting the definition above?	Yes ❒	No ❒
7.14 If you answered yes to the above question, do you consent to make a prohibited Employment Declaration and a Background Check, as prescribed by the relevant law?	Yes ❒	No ❒
Please attach your current Working With Children Clearance Certificate to this application		

Section 8 Emergency Contact

Please nominate a medical practitioner accredited at the Unitas Sunshine Private Hospital with an equivalent scope of practice where you are seeking accreditation who has agreed to be contacted and deputise for you in the event that you are unavailable. *(NB: Not applicable for Surgical Assistants):*

Name:			
Specialty:			
Contact Numbers:	Home:	Mob:	Pager:
Facility:			

Authority:

- I hereby apply for accreditation at *UNITAS SUNSHINE PRIVATE HOSPITAL* for the clinical privileges I have specified and as attached to this application.

- In making this application I acknowledge and agree that:
  - ❖ I have received a copy of the Somewhere Hospital By-Laws.
  - ❖ I have read and understood the Somewhere Hospital By-Laws.
  - ❖ If I am appointed I will abide by the Somewhere By-Laws, as amended from time to time.
  - ❖ The Hospital executives, its officers and the medical advisory committee may seek information about my past experience, clinical performance and current fitness.
  - ❖ If I have provided misleading, deceptive or inaccurate information or information which is likely to mislead, deceive or be inaccurate (including through omission), Somewhere may (in its absolute discretion) immediately proceed to suspension or termination of my Accreditation.
  - ❖ I will immediately notify the CEO of UNITAS *SUNSHINE PRIVATE HOSPITAL* of any material changes or additional relevant information with respect to the information already provided by me in connection with this application so that it remains accurate while the application is under consideration.
  - ❖ I will also notify the CEO or the Director of Clinical Services in any of the following events (but not limited to the following events):
    - ❖ The relevant statutory professional registration board makes an adverse finding against me or suspends, revokes or places any limitation on my registration;
    - ❖ I do not have professional indemnity insurance cover in place for any reason;
    - ❖ I am convicted of a serious criminal offence.
  - ❖ I understand that my Appointment as an Accredited Practitioner, if granted, will be reviewed in 5 years or earlier if considered necessary.

***NOTE**: Receipt of certificate of coverage from your medical defence organisation/fund or professional indemnity insurer and certificate of registration **MUST** accompany this application.*

Applicant's Name:			
Signature		**Date:**	
Witness Name:			
Signature:		**Date:**	

Sponsoring practitioner must complete this part of the form

I, _____ endorse this application from

Sponsoring practitioner's name

_____

Applicant's name

_____ _____

Signature of sponsoring practitioner *Date*

ANNEXURE B1 LETTER TO REFEREE (NON MENTAL HEALTH)

[INSERT DATE]

[INSERT REFEREE'S NAME AND ADDRESS]

Dear [INSERT REFEREE'S NAME]

Re: Professional referee report for credentialing at [INSERT NAME OF ORGANISATION] as a Visiting Medical Officer (VMO) in the speciality of [INSERT SPECIALTY]

for: (the applicant)

The above practitioner has applied for credentialing as a VMO [INSERT SPECIALTY] at [Insert Hospital]. They have listed you as a professional referee.

Based on your professional knowledge of [INSERT APPLICANT'S NAME], we would appreciate a comprehensive appraisal of them. If this is acceptable to you I would appreciate you emailing or faxing your referee report to me. Please do not hesitate to contact me if there is anything else you would like to discuss about the applicant.

1. Do you have sufficient recent exposure to [Insert applicant's name] clinical work to give a reliable reference? Please comment on how long you have known the applicant, in what capacity and over what period of time you worked with the applicant in this capacity.

1. How would you describe [Insert applicant's name] professional knowledge?

2. How would you describe [Insert applicant's name] technical skills?

3. How would you describe [Insert applicant's name] clinical judgement?

4. Are you able to confirm the extent of [Insert applicant's name] training in the specialty they have applied for?

5. How would you describe [Insert applicant's name] participation in their continuing professional development?

6. Are you able to attest to [Insert applicant's name] good character?

7. How would you describe [Insert applicant's name] ability to work with others (e.g. nursing and allied health staff as well as junior doctors and peers)?

8. How would you describe [Insert applicant's name] communication with patients?

9. [Insert applicant's name] is requesting that their scope of clinical practice be defined in [Insert as appropriate]. Based on your experience with [Insert applicant's name] do you agree that this is appropriate?

10. To your knowledge, has [Insert applicant's name] ever been the subject of disciplinary action through the course of their employment as a medical practitioner?

11. Are you aware of any problems with [Insert applicant's name] being unavailable to be contacted about their patients' care or not arranging reliable locum cover when necessary?

12. Are you aware of any health or personal issues (including drug and alcohol problems) that might compromise the applicant's ability to work in their area they are seeking credentialing?

13. Are there any other issues that you think are, or ought to be, relevant to the credentialing of this applicant?

Please also report on the confidence you would hold in the applicant for appointment as an accredited practitioner to this Hospital. The information you provide will be treated in confidence.

Your Name: _____

Signature: _____

Date: _____

Thank you for providing this information to assist us in the credentialing process.

Yours sincerely

[NAME]
Chief Executive Officer

ANNEXURE B2 LETTER TO REFEREE (MENTAL HEALTH)

[INSERT DATE]

[INSERT REFEREE'S NAME AND ADDRESS]

Dear [INSERT REFEREE'S NAME]

Re: Professional referee report for credentialing at [INSERT ORGANISATION'S NAME] as a Visiting Medical Officer (VMO) in the speciality of Psychiatry
for: (the applicant)

The above medical practitioner has applied for credentialing at [INSERT ORGANISATION'S NAME] as a VMO psychiatrist and has listed you as a professional referee. Based on your professional knowledge of [Insert name of applicant], we would appreciate a comprehensive appraisal of them. If this is acceptable to you I would appreciate you emailing or faxing your referee report to me. Please do not hesitate to contact me if there is anything else you would like to discuss about the applicant.

1. Do you have sufficient recent exposure to [Insert applicant's name] clinical work to give a reliable reference? Please comment on how long you have known the applicant and in what capacity and over what period of time you worked with the applicant in this capacity.

2. Does [Insert applicant's name] have the clinical skills and judgement to provide expert psychiatric care to inpatients of a psychiatric hospital and to manage their care upon discharge from the hospital or refer them to other practitioners as appropriate?

3. Does [Insert applicant's name] have sufficient judgement about their own limitations and the need for appropriate referral and second opinions when clinically necessary?

4. Does [Insert applicant's name] work well with nursing and allied health staff as well as junior doctors and peers? In other words: Does the applicant work in a collegial way or are they hard to get on with?

5. Does [Insert applicant's name] have problems with interpersonal skills that impact on their ability to interact in a clinically appropriate way with staff, patients and their families?

6. Does [Insert applicant's name] have any areas of clinical practice that need improvement in order for them to work unsupervised in caring for patients in a psychiatric hospital?

7. Does [Insert applicant's name] have any areas of clinical practice that might be considered unorthodox or non-mainstream?

8. Does [Insert applicant's name] handle emergency situations competently and are they able to manage a high sustained workload without compromising quality?

9. Are you aware of any problems with [Insert applicant's name] being unavailable to be contacted about their patients' care or not arranging reliable locum cover when necessary?

10. Are you aware of any health or personal issues (including drug and alcohol problems) that might compromise [Insert applicant's name] ability to work in their area they are seeking credentialing?

11. Are there any other issues that you think are, or ought to be, relevant to the credentialing of [Insert applicant's name]?

Please also report on the confidence you would hold in the applicant for appointment as an accredited practitioner to this Hospital. The information you provide will be treated in confidence.

Your Name: _____

Signature: _____

Date: _____

Thank you for providing this information to assist us in the credentialing process.

Yours sincerely

[NAME]
Chief Executive Officer

ANNEXURE C ADDITIONAL CRITERIA FOR ACCREDITATION

1. Appropriate professional fellowship or equivalent.

2. Membership of an appropriate craft group, society or association or equivalent (where applicable).

3. Specialist recognition (if appropriate).

4 (a) Three peer referees who can attest recent practice is consistent with the criteria contained within the By-Laws and are not professionally or financially related to the applicant (refer Annexure B); and

(b) Such referee(s) should be familiar with the current professional capabilities of the applicant for appointment.

5. Any specific criteria for the granting of Clinical Privileges as adopted by the Hospital from time to time.

6. Be a regular attendee at peer review/quality assurance/clinical audit activities as required and produce evidence on this to the satisfaction of the Medical Advisory Committee.

7. Any other criteria for appointment including for example teaching commitment if the Hospital is affiliated with a university medical school.

8. Arranges an appropriate substitute Accredited Practitioner when unavailable and provides adequate notice to the Hospital of transfer of patient care to the substitute Accredited Practitioner.

9. Attending to patients in person with reasonable frequency.

ANNEXURE D MODEL CRITERIA FOR EACH ACCREDITATION CATEGORY

Type of Appointment	Details
Specialist Practitioner & Staff Specialist	• Specialist with an Australian Fellowship or equivalent; recognised under the Health Insurance Act 1973 as a specialist. • May admit and treat patients within the terms of their Clinical Privileges. • Responsible for the clinical care of their inpatients • Participates in continuing education activities of the Hospital
General Practitioner	• FRACGP or equivalent. • May admit and treat patients within the terms of their Clinical Privileges. • Responsible for the clinical care of their inpatients • Participates in continuing education activities of the Facility
Surgical Assistant Medical (specialty) (No admitting rights)	• General Practitioner or Specialist Practitioner with Australian Fellowship or equivalent • May not admit and/or treat patients, but may assist in theatres and visit patients in ward areas, examine medical records for their patients, but not initiate or change treatment orders. • Credentials and Clinical Privileges Committee may limit Clinical Privileges of theatre assistant role to a particular specialty or surgeon. • May participate in continuing education activities of the Facility.
Dentist or Dental Specialist	• Dentist who may admit and treat dental inpatients (usually day only patients requiring operating theatre procedures) within the terms of their Clinical Privileges. • Participates in continuing education activities of the Hospital. • Responsible for clinical care of their inpatients.
Employed Medical Officer (House Medical Officer/ Career Medical Officer /Resident Medical Officer /Registrar) (No admitting rights)	• Current Medical Registration in relevant state and minimum two years post-graduate experience • Senior Clinician able to demonstrated proficiency in the services as provided by the hospital (e.g. General Medicine, General Surgery, Rehabilitation, Obstetrics, Paediatrics) • Participates in continuing education and quality activities of the Hospital • May not admit patients, but can treat patients in consultation with the Specialist Practitioner/VMO/Staff Specialist. • May assist in theatres in an emergency
Consultant Emeritus	• Medical Practitioner or Dentist who has provided distinguished service to the Hospital and who has retired from active practice or is otherwise a member of the medical or dental profession of outstanding merit or extraordinary accomplishment and is awarded this title by Executive Management Committee.
Consultant Specialist/ Consultant General Practitioner (with visiting rights only and no admitting rights)	• Consultant Specialist: • Specialist with an Australian Fellowship or equivalent; recognised under the Health Insurance Act 1973 as a specialist.

	• Consultant General Practitioner: • FRACGP or equivalent advises on treatment of patients in a consultant role with the Admitting Practitioner. • Refers to both the above: • Participates in continuing education activities of the hospital.
Surgical Assistant (Non Medical)with no admitting rights	• To be at the sole discretion of the Executive Director following review of application.
University student	• Arrangement with University (organisational policy) • May not admit or treat patients and must be supervised at all times

ANNEXURE E1 MODEL CRITERIA FOR THE DELINEATION OF CLINICAL PRIVILEGES

The model criteria are the primary fields of Clinical Privileges at Unitas Healthcare, Sunshine Private Hospital. The model criteria are for guidance in relation to categories that need to be taken into account regarding Credentials and Clinical Privileges. There may be occasions where practitioners are not covered in the categories listed below.

IMPORTANT NOTICE: 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 community, including but not limited to participation in recognised quality assurance 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.

MEDICAL PRACTITIONERS:

Anaesthesia	
Cardiac	• FANZCA or equivalent. • Where hospital is affiliated to a University, then demonstrated current experience in Cardiac Anaesthesia in a teaching hospital of more than three years is required.
General	• FANZCA or equivalent, including Obstetric, Regional, Pain Management.
Paediatric	• FANZCA or equivalent, and demonstrated current experience in paediatric anaesthesia.
Intensive Care	
Intensive Care	• FANZCA (Faculty of Intensive Care) or FRACP or equivalent. • Faculty of Intensive Care Certificate or equivalent. • Where hospital is affiliated with a university, current appointment to a Teaching Hospital Intensive Care Unit.
Cardiology	
Cardiology	• FRACP or equivalent, • Full member of the Cardiac Society or equivalent. • Those Practitioners seeking admitting rights in the Intensive Care (Coronary Care) Unit should have worked in a Coronary Care Unit of a major hospital during the past two (2) years and be supported by three referees who can attest to this activity.
TOE (trans-oesophageal echo-cardiography)	• Current appointment to a Teaching Hospital • Cardiology Department and be performing regular TOE lists.
Adult Echocardiography	• Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Echo_Training_Guidelines_April2004.pdf
Colorectal Surgery	
Colorectal Surgery	• FRACS or equivalent and recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (Royal Australasian College of Surgeons, Royal Australasian College of Physicians and the Gastroenterological Society of Australia) or equivalent, including specialty training in Colorectal Surgery.

Laparoscopic Surgery	• Evidence of advanced surgery or training in laparoscopic surgery.
Dermatology	
General	• FACD or equivalent
Emergency Medicine	
General	• FACEM or equivalent
ENT Surgery	
ENT Surgery - Adult	• FRACS (Otolaryngology, head and neck surgery) or equivalent. • Demonstrable competency in special areas such as Head & Neck, Paediatric and Paediatric Endoscopic ENT surgery.
ENT Surgery – Paediatric	• FRACS (Otolaryngology, head and neck surgery) or equivalent. • Completion of a recognised formal training program in paediatric ENT surgery
Paediatric Endoscopic ENT Surgery	• FRACS or equivalent • Completion of a recognised formal training program in Paediatric Endoscopic Otolaryngology
Head and Neck	• FRACS (Otolaryngology) • Member of the Australian and New Zealand Head and Neck Cancer Society or equivalent
Gastroenterology	
Gastroenterology	• FRACP or equivalent.
Endoscopy	• Recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
ERCP (Endoscopic Retrograde Cholangio-Pancreatography)	• FRACP or FRACS or equivalent. • Those practitioners wishing to have admitting rights in ERCP should have worked in ERCP in a major hospital during the past two years and be supported by two referees who can attest for this recent activity
General Practitioner	
GP	• FRACGP or equivalent
General Surgery	
General Surgery Adult	• FRACS or equivalent
Bariatric Surgery	• FRACS or equivalent • RACS CME compliance certificates (or recognized equivalent)
Endoscopy	• Recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
Laparoscopic Surgery	• FRACS or equivalent • Provide evidence of advanced training in Laparoscopic Surgery.
Paediatric Surgery	• FRACS (Paediatric Surgery) or equivalent.
Oncoplastic Breast Surgery	• FRACS or equivalent • Full member of Breast Surganz, completed level 1 and level 2 oncoplastic courses or equivalent overseas courses
Gynaecology	
Gynaecology – general	• FRANZCOG or equivalent.
Gynaecological Oncology	• FRANZCOG/CGO – Certificate in Gynaecological Oncology or equivalent.
Advanced Endoscopic Surgery	• FRANZCOG or equivalent. • Provide evidence of completion of recognised formal training in

	advanced Endoscopic Surgery.
Occupational Medicine	
General	• FAFOM or equivalent.
Oncology	
Medical Oncology	• FRACP or equivalent
Ophthalmology	
Adult	• FRANZCO • FRANCS, FRACO or equivalent.
Paediatric	• FRANZCO • FRANCS, FRACO or equivalent.
Orthopaedics	
Orthopaedic Surgery and Hand Surgery - Adult	• FRACS (Orthopaedic Surgery) or equivalent. • Where relevant, member of Australian Hand Surgery Group or equivalent desirable • Demonstrable competency in relevant area(s): - Major Joint - Spinal - Hand & Upper Limb - Foot & Ankle
Orthopaedic Surgery and Hand Surgery - Paediatrics	• FRACS (Orthopaedic Surgery) or equivalent. • Completion of a recognised formal training program in paediatric orthopaedics • Where relevant, member of Australian Hand Surgery Group or equivalent is desirable • Demonstrable competency in relevant area(s): - Major Joint - Spinal - Hand & Upper Limb - Foot & Ankle
Paediatric Medicine	
General	• FRACP (Division of Paediatrics) or equivalent
Anaesthetics	• FANZCA or equivalent • Demonstrated current experience in paediatric anaesthesia.
Paediatric Surgery	
Paediatric Surgery	• FRACS (Paediatric Surgery) or equivalent.
Anaesthetics	• FANZCA or equivalent • Demonstrated current experience in paediatric anaesthesia.
Palliative Care	
	• FRACP or FANZCA or equivalent.
Pathology	
General	• FRCPA or equivalent.
Infection Control	• FRACP and/or FRCPA or equivalent.
Physician/Internal Medicine	
Infectious Diseases (IND)	• FRACP or FRCPA or equivalent
General Medicine	• FRACP or equivalent.
Clinical Haematology	• FRCPA or equivalent.

Clinical Oncology (ONC)	• FRACP or equivalent
Endocrinology (END)	• FRACP or equivalent.
Geriatrics (GER)	• FRACP or equivalent.
Neurology (NEU)	• FRACP or equivalent.
Renal Medicine (REN)	• FRACP or equivalent.
Respiratory Physician	• FRACP or equivalent. • Those wishing to perform respiratory procedures (e.g. Fbreoptic Bronchoscopy, medical pleuroscopy, Throracocentesis and endobrachial valves) should have recognition by the College of Physicians and Thoracic Society of Australia and NewZealand (TSANZ) or equivalent. • Those wishing to report Sleep Studies should be part of the Australian Sleep association (ASA) or equivalent
Rheumatology (RHE)	• FRACP or equivalent.
Plastics and Reconstructive Surgery	
Hand Surgery	• FRACS (Plastic Surgery) or FRACS or equivalent
Facio Maxillary Surgery	• FRACD (OMS) or FRACS (Plastic Surgery) or FRACS or equivalent
Plastic, Reconstructive and Aesthetic Surgery	• FRACS (Plastic Surgery) or FRACS or equivalent
Head and Neck Surgery	• FRACS (Plastic Surgery) or FRACS or equivalent • Member of the Australian and New Zealand Head and Neck Society or equivalent
Podiatric Surgery	
Podiatric Surgery Adult	• FRACS (Orthopaedics), FACPS or equivalent • Where relevant, member of the Australian College of Podiatric Surgeons or equivalent desirable • Demonstrable competency in relevant area(s): • Podiatric surgery
Podiatric Surgery Paediatrics	• FRACS (Orthopaedics), FACPS or equivalent • Where relevant, member of the Australian College of Podiatric Surgeons or equivalent desirable • Completion of a recognised formal training program in paediatric podiatric surgery • Demonstrable competency in relevant area(s): - Podiatric surgery
Psychiatry	
General	• FRANZCP or equivalent
Sub Specialty	• FRANZCP or equivalent. Sub specialities include Adolescent, Paediatric, forensic, Psychogeriatric, • Those wishing to perform TMS therapy should have relevant training in the past two (2) years and be supported by three (3) referees who can attest to this recent activity
Radiology	
Radiology	• FRACR or equivalent. • Those wishing to have interventional rights should have relevant training in the past two (2) years and be supported by three (3) referees who can attest to this recent activity.
Rehabilitation Medicine	
General	• FAFRM (RACP) or equivalent and demonstrate expertise in the relevant modality.

Urology	
Adult	• FRACS (Urology) or equivalent. • Demonstrable competency in - Lithotripsy - Laser Lithotripsy
Paediatric	• FRACS (Urology) or equivalent plus demonstrate current experience in paediatric urology
Vascular Surgery	
Vascular Surgery	• FRACS (Vascular Surgery) or equivalent, or; • FRACS or equivalent with completion of a specialty training program in Vascular Surgery. • Those wishing to have interventional rights (Angiography based procedures) should have relevant training in the past two (2) years and be supported by three (3) referees who can attest to this recent activity.

ANNEXURE E2 ADDITIONAL MODEL CRITERIA FOR DEFINING THE SCOPE OF CLINICAL PRACTICE - DENTISTS:

1. Introduction

Credentialing in dentistry allows a dental practitioner to provide clinical services at a healthcare facility. The process of credentialing should be performed by a committee appointed by the facility. Credentialing is recognised as an integral part of processes for the maintenance of the professional standards necessary for all Members of the relevant state's Dental Board and Australasian Dental Association and for other dentists working in any institution.

2. Scope of Dental Practice

The scope of dental practice or delineation of clinical privileges to be undertaken at Unitas Healthcare, Sunshine Private Hospital recognises that all dentists are registered to provide all dental treatment modalities.

Credentialing Committees may consider the credentialing and delineation of clinical privileges of a dentist under various circumstances. These include, but may not be restricted to, the following:

- Dentists being employed by hospitals with dental clinics on a locum (casual), part-time basis
- Private dentists seeking to make use of hospital operating theatres – usually for patients requiring treatment under general anaesthetic.

A patient's need to have their treatment provided under general anaesthetic can be the result of a number of different circumstances. Some special needs patients (e.g. young children requiring extensive restorative care, disabled or mental health patients) may need to be treated under general anaesthetic whatever their treatment requirements. This means that all types of dental treatment as described by the Australian Dental Association (ADA) Schedule of Dental Services fit within the delineation of clinical privileges.

The Australian Schedule of Dental Services and Glossary is accepted as the definitive coding system of dental treatment and endorsed by the National Coding Centre.

3. Qualifications

3.1 General practitioner dentists

The following qualifications are prescribed as necessary qualifications for registration as a dentist:

BDS – Bachelor of Dental Surgery

BDSc – Bachelor of Dental Science

BDent – Bachelor of Dentistry (graduated after 2002)

There is no difference between the degrees. State licensing boards accept each degree as equivalent; all degrees allow licensed individuals to practice the same scope of general dentistry.

NB: A Dental Surgeon is not a dental specialist. A dental surgeon is a normal dentist. A dentist can choose to call themself a dental surgeon.

3.2 Dental/Oral care - Specialists

The ASA, State and Territory dental boards in Australia recognise 10 fields as dental specialties:

- dento-maxillofacial radiology,
- endodontics,
- oral and maxillofacial surgery,
- oral pathology and oral medicine,
- oral surgery,
- orthodontics,
- pedodontics or paediatric dentistry,
- periodontics, prosthodontics,
- special needs dentistry and
- public health dentistry.

Dentists offering cosmetic dentistry services are featured in the category Dental/Oral care / Cosmetic dentistry.

Additional post-graduate training is required to become a dental specialist. Dental/oral health specialists include the following:

Dento-maxillofacial radiography	That part of dental practice which deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions. A Specialist in dento-maxillofacial radiology shall have the title of **Dento-maxillofacial Radiologist**.
Endodontics	That part of dental practice which deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues. A Specialist in endodontics shall have the title of **Endodontist**.
Oral and Maxillofacial Surgery	That part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures. A Specialist in oral and maxillofacial surgery shall have the title of **Oral and Maxillofacial Surgeon**.
Oral Medicine	That part of dental practice which deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment. A Specialist in oral medicine shall have the title of **Oral Physician**.
Oral Pathology	That part of dental practice which deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations. A Specialist in oral pathology shall have the title of Oral Pathologist.

Orthodontics	That part of dental practice which deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means. A Specialist in orthodontics shall have the title of Orthodontist.
Paediatric Dentistry	That part of dental practice which deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems. A Specialist in paediatric dentistry shall have the title of Paediatric Dentist or Paedodontist.
Public Health Dentistry	That part of dental practice which deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis. A Specialist in Public Health Dentistry shall have the title of Public Health Dentist.
Special Needs Dentistry	That part of dental practice which deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans. A Specialist in Special Needs Dentistry shall have the title of Special Needs Dentist.

4. Membership

4.1 Member of Royal Australasian College of Dental Surgeons – General Stream

MRACDS in the General Stream is a clinically relevant educational program designed specifically for General Dental Practitioners (GDPs). This achievable, flexible program enables GDPs to advance their practical GP clinical skills whilst at the same time gaining valuable CPD credits and achieving a qualification in General Dental Practice.

MRACDS is a 2 year educational program (up to a maximum of 3 years) involving completion of:

- The equivalent of 20 days appropriate CPD courses to underpin core and elective modules
- Selected reading and self education
- College-run assessment components (open book short answer questions, case reports and a *viva voce* examination).

The core modules include practice management, infection control, diagnosis and treatment planning, medical emergencies, law and ethics and risk management and jurisprudence, pain and pain management, and therapeutics.

The MRACDS program provides a forum for GDPs to update their clinical and dental practice skills in a favourable supportive environment. It also provides a pathway to FRACDS, with holders of MRACDS being eligible to apply for exemption from the Primary Examination and then able to present for the Final Examination.

NB: This does not expand their scope of practice beyond that of a general practitioner dentist.

4.2 Member of the Royal Australasian College of Dental Surgeons –Special Field

Membership is open to specialists in the fields of Endodontics, Oral Medicine, Orthodontics, Paediatric Dentistry, Prosthodontics and Special Needs Dentistry.

Those specialists who have completed appropriate postgraduate programs prior to 30 June 2008 are eligible to apply for recognition leading to the award of Membership

- FRACDS(Endo)
- FRACDS(OMS)
- FRACDS(OralMed)
- FRACDS(Orth)
- FRACDS(Paed)
- FRACDS(Perio)
- FRACDS(Pros)
- FRACDS(SND)

5. Restrictions and Limitations

Function	***Usual response***
What is the position going to do? What elements of service provision are involved i.e. assessment and treatment and/or surgical procedures? What procedures or interventions are involved in the service?	*Provide dental treatment within the ADA Schedule of Dental Services As above* *Relative analgesia, conscious sedation or General Anaesthetic under the control of an Anaesthetist, in accordance with relevant State/s Dental Board Code of Practice*
Skills	
What extra skills/experience is needed to accomplish the function?	*Nil*
Equipment and Services	
What range of equipment is needed and what specialty training is required to use it? What services are required to support this practice?	*Dental cart – no special training* *Dental assisting – dentist's own staff (with Certificate III in Dental Assisting)*
Location/ Time	
Are the facilities to be used appropriate for this service? Are the services to be provided outside of normal working hours?	*Yes* *Yes / No*

When the credentialing of dental staff is undertaken, a registered dentist will ordinarily be a member of the Committee.

ANNEXURE F LETTER OF REJECTION TO APPLICANT FOR INITIAL APPOINTMENT

[INSERT DATE]

[INSERT APPLICANT'S NAME AND ADDRESS]

Dear [INSERT APPLICANT'S NAME]

I refer to your application for accreditation [INSERT ORGANISATION'S NAME] dated [DATE OF APPLICATION].

Following careful consideration of your application in accordance with the Unitas Sunshine Private Hospital By-Laws, I am writing to inform you that your application for initial appointment to the Hospital has not been successful.

Thank you for your interest in [INSERT ORGANISATION'S NAME].

Yours sincerely

[NAME]
Chief Executive Officer

ANNEXURE G LETTER OF INITIAL APPOINTMENT

[INSERT DATE]

[INSERT APPLICANT'S NAME AND ADDRESS]

Dear [INSERT APPLICANTS NAME]

I refer to your application for accreditation to [INSERT FACILITY NAME] dated [DATE OF APPLICATION].

Following careful consideration of your application in accordance with the Unitas Sunshine Private Hospital By-Laws, I am writing to inform you that your application for initial appointment to [INSERT NAME] Private Hospital has been successful as follows:

Accreditation:
e.g. Specialist Psychiatrist

Scope of Practice (Clinical Privileges):
General Adult Psychiatry
Electro-Convulsive Therapy

Your accreditation commences from the date of this letter and is effective until [INSERT DATE] DEPENDING ON YEARS OF ACCREDITATION - MAXIMUM 5 YEARS].

Please note that 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, including but not limited to participation in recognised quality assurance 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.

Please sign the duplicate of this letter and return it to me as soon as possible to confirm your acceptance and your agreement to abide by the Unitas Sunshine Private Hospital By-Laws.

I look forward to working with you in the delivery of excellent health care to our patients.

Yours sincerely

[NAME]
Chief Executive Officer

I have read the above letter and confirm acceptance of my appointment, the terms of my appointment, and agree to abide by the Unitas Sunshine Private Hospital By-Laws.

Signature: _____
Applicant's signature

Name: _____
Name of Applicant

Date: _____

ANNEXURE H LETTER FOR TEMPORARY APPOINTMENT

[DATE]

[INSERT APPLICANT'S NAME AND ADDRESS]

Dear Dr [INSERT APPLICANTS NAME]

Temporary Appointment

I refer to your application for temporary appointment to [Insert Facility Name] dated [DATE OF APPLICATION] and am pleased to advise that your application for temporary accreditation has been approved for the following clinical privileges:

Accreditation:
e.g. Specialist Psychiatrist

Scope of Practice (Clinical Privileges):
General Adult Psychiatry
Electro-Convulsive Therapy

Your temporary appointment starts from the date of this letter and concludes [INSERT NUMBER] months later on [INSERT DATE].

Your permanent appointment will be considered at the next meeting of the [Insert Facility Name] Credentials Committee scheduled for [INSERT DATE].

Please sign the duplicate of this letter and return it to me as soon as possible to confirm your acceptance and your agreement to abide by the Unitas Sunshine Private Hospital By-Laws.

I look forward to working with you in the delivery of excellent health care to our patients.

Yours sincerely

[NAME]
Chief Executive Officer

ANNEXURE I PECUNIARY INTEREST / CONFLICT OF INTEREST / MATERIAL PERSONAL

Explanatory Note: Health professionals encounter a variety of circumstances in their day-to-day work, which could give rise to potential conflicts of interest. Where a possible pecuniary interest / conflict of interest exists, e.g. where a medical practitioner is a significant competitor in economic terms of an applicant seeking appointment at the same Unitas Sunshine Private Hospital facility, the composition of the Medical Advisory Committee (MAC) for credentialing is to take this into account.

The member of the MAC and/or the medical practitioner should report the possible conflict of interest to the Chief Executive (or authorised delegate[s]) who will assess if the possible conflict warrants the medical practitioner not being involved in the credentialing of the applicant.

[DATE]

[INSERT NOTIFIER'S NAME AND ADDRESS]

Dear [INSERT CEO'S NAME]

RE: Notifying of Pecuniary Interest / Conflict of Interest / Material Personal

I advise of a possible conflict of interest in regards to:

- List the issue(s)
-

I await your assessment and decision in regards to this notification.

Yours Sincerely

SIGNATURE
[INSERT NAME OF NOTIFIER]
[POSITION]

ANNEXURE J MODEL CRITERIA FOR THE DELINEATION OF CLINICAL PRIVILEGES ALLIED HEALTH

As per Annexure E1 all Accredited Allied Health 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 community, including but not limited to participation in recognised quality assurance activities, recognised continuing allied health education and professional development activities. Accredited Allied Health 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.

Chiropractic	A person is entitled to be registered as a Chiropractor if they fulfil the requirements of the relevant State / Territory Act and hold a diploma, certificate or other equivalent qualification, which is satisfactory to the relevant State / Territory Regulatory/Licensing body.
Physiotherapy	A person is entitled to be registered as a Physiotherapist if they fulfil the requirements of the relevant State / Territory Act and hold a degree, diploma or other equivalent qualification, which is satisfactory to the relevant State / Territory Regulatory/Licensing body.
Podiatry	A person is entitled to be registered as a Podiatrist if they fulfil the requirements of the relevant State / Territory Act and have completed a course of training and study as determined/recognised by the relevant State / Territory Regulatory/Licensing body.
Pharmacy	A person is entitled to be registered as a Pharmacist if they fulfil the requirements of the relevant State Act and the person holds a degree or its equivalent as approved by the relevant State / Territory Regulatory/Licensing body.
Speech Pathology	A person is entitled to be registered as a Speech Pathologist if they fulfil the requirements of the relevant State / Territory Act and State / Territory Regulating body and hold a degree, diploma or certificate, which is recognised by the relevant State / Territory Regulatory/Licensing body.
Psychology	A person is entitled to be registered as a Psychologist if they fulfil the requirements of the relevant State / Territory Act and hold a degree or its equivalent, which is recognised by the relevant State / Territory Regulatory/Licensing body.
Occupational Therapy	A person is entitled to be registered as an Occupational Therapist if they fulfil the requirements of the relevant State / Territory Act and hold a degree, diploma or certificate recognised by the relevant State / Territory Regulatory/Licensing body.
Non-Medical Surgical Assistant	Possess an appropriate post-graduate qualification suitable for Surgical Assistant. Indemnity Insurance Certificate (to be reviewed by Chief Executive Officer).

NOTE: *A reference to "State / Territory Act and/or Regulation" in this Annexure is a reference to the relevant legislation of the relevant State / Territory (as may be amended from time-to-time), which sets out the statutory requirements for healthcare professionals to be registered/licensed.*

ANNEXURE K CONSIDERATION OF ACCREDITED PRACTITIONER APPLICATION FOR APPOINTMENT FORM

PRACTITIONER NAME: _____

PROVIDER NUMBER: _____

APPLICATION FORM COMPLETED & CV RECEIVED Y ❑ N ❑	DATE:	PRIVILEGES GRANTED Y ❑ N ❑	DATE:
Copy of Registration Received Y ❑ N ❑	DATE:	Approved by Licensee as evidenced by the letter sent on behalf of the Licensee, confirming the appointment	DATE:
Copy of certificate of currency for Medical Indemnity Insurance received. Y ❑ N ❑	DATE:	Applicant Notified Y ❑ N ❑	DATE:
Copy of criminal record check received. Y ❑ N ❑	DATE:	Copy filed	DATE:
Copy of Post Graduate Qualifications and Copy of College Fellowship Received Y ❑ N ❑	DATE:	Application entered into Hospital IT Management System Y ❑ N ❑	DATE:
Copy of certificate showing participation in Continuing Medical Education (where available) Y ❑ N ❑	DATE:	Registration/Insurance Renewal Dates noted Y ❑ N ❑	DATE:
Relevant References Received Y ❑ N ❑ References Reviewed Y ❑ N ❑	DATE: DATE: Name of Reviewer:	Date for re-application	DATE:
Recommended by Medical Advisory Committee	DATE: Signature:		
Recommended by Chief Executive Officer	DATE: Signature:		

Note: *To ensure the hospital is fully comply with the requirement to document the credentialing process, it is recommended that a photocopy* ***of this page be circulated with the agenda and a copy attached to the minutes of the Credentialing Committee meeting*** *at which the application is approved. The completed original of this form should remain with the complete application.*

ANNEXURE L MODEL CRITERIA PERIOPERATIVE NURSE SURGICAL ASSISTANT

Perioperative Nurse Surgeon Assistants (PNSA) are registered nurses who undertake an advanced practice nursing role as the first assistant in surgery. The PNSA is required at all times to work collaboratively with surgeons and other clinical staff to provide patients with the best possible quality of care. The PNSA is qualified to also provide patients an expanded role of care in all perioperative areas including pre-operative, intraoperative and post-operative care.

The Perioperative Nurse Surgical Assistant is required to satisfy credentialing requirements of the Unitas Hospital and fulfil the following requirements:

a) Hold current registration as a registered nurse with AHPRA in Australia.

b) Have a minimum of three (3) years perioperative experience if a post graduate certificate in perioperative nursing has been completed or five (5) years experience if a postgraduate certificate in perioperative nursing has not been completed.

c) Have successfully completed or be currently enrolled in a postgraduate degree (minimum Graduate Certificate level) in PNSA studies by an approved university.

d) Have evidence of public liability and professional indemnity insurance to the minimum level of twenty (20) million dollars.

e) Maintain professional competencies by undertaking continuous professional education (CPD) and participate in learning opportunities in the field of surgical assisting with a yearly assessment by an assessor as approved by the hospital facility.

f) Meet the code of conduct for the AANSA (Australian Association of Nurse Surgical Assistants).

g) Fulfil the minimum practicum hours of supervised surgical assisting hours as detailed by the approved university.

APPENDIX M1 – REFEREE REPORT – TELEPHONE INTERVIEW VERIFICATION

Unitas Sunshine Private Hospital must obtain references from three (3) referees, preferably within the specialty being applied for, who are independent of the applicant, with no conflict of interest, and who can attest to the applicant's professional performance within the previous three years.

All written references must be verified verbally.

The following document provides a standardised telephone interview for the purposes of obtaining or verifying a reference.

Name of applicant:
Application number/file number/personnel number:
Clinical specialties applied for:
Telephone interviewer:
Date of interview:
Reference provided by:
Current position of referee:
Contact details of referee:

Introduction

<Insert name of applicant> has applied for credentialing and defining their scope of clinical practice at <insert name of organisation>. They have listed you as a referee.

Based on your professional knowledge of <insert name of applicant>, we would appreciate a comprehensive appraisal of them.

This interview will take approximately 10 minutes and will cover clinical competence, ability to work with others, personal integrity and other information relevant to this practitioner's qualifications and practice.

Before we start this interview, there are two points that are important for you to be informed about:

1. I advise you (the referee) that the information that you provide in relation to the applicant may be accessible by the applicant at their request, or by others as required by law or under the *Freedom of Information Act 1982* and/or the *Privacy Act 1988 and its Amendments.* If you would like to see the written comments about this conversation, you can request them from me as the person undertaking the referee checks.

14. The information you provide in relation to the applicant is subject to the usual protection under defamation law. It is a complete defence to a defamation claim if the words complained of are the truth or a fair comment made in the public interest. The statements you make will attract qualified privilege, that is, in order for the applicant to succeed in a defamation claim they would have to prove that your words were motivated by malice.

Are you happy to proceed with this reference?

1. Relationship of referee to applicant

How long have you known <insert name of applicant>?
In what capacity have you worked with <name of applicant>?
Over what period of time did you work with <name of applicant> in this capacity?

2. Professional knowledge, skills and attitude

How would you describe <name of applicant>'s professional knowledge?
How would you describe <name of applicant>'s technical skills?
How would you describe <name of applicant>'s clinical judgement?
How would you describe <name of applicant>'s participation in her/his <omit as appropriate> continuing medical education?
How would you describe <name of applicant>'s participation in her/his <omit as appropriate> continuing professional development?
How would you describe <name of applicant>'s ability to work with others?
How would you describe <name of applicant>'s communication with patients? <insert other fields as relevant to the position description, for example, leadership or management>
<Name of applicant> is requesting that their scope of clinical practice be defined in <insert as appropriate>. Based on your experience with <name of applicant> do you agree that this is appropriate? ❒ Yes ❒ No ❒ Other

Comments:	
Please explain any reservations or concerns regarding the scope of clinical practice requested by the applicant:	
To your knowledge, has <name of applicant> ever been the subject of disciplinary action through the course of her/his <omit as appropriate> employment as a medical practitioner? *If yes, please explain:*	❒ Yes ❒ No ❒ No information
Do you have any additional comments, information, or recommendations that may be relevant to <name of applicant>'s application?	
Signature of interviewer	Date: / /20