TOOWOOMBA HOSPICE ASSOCIATION INC

Private and Confidential

Application for Clinical Privileges - Allied Health and Complementary Therapies

Please print, tick, or circle relevant answers and return the completed form, with copies of requested documents to The Toowoomba Hospice Director of Nursing: director@toowoombahospice.org.au or Administration Assistant admin@toowoombahospice.org.au
FAX: (07) 46 598 511

New Application ☐ **Renewal Application** ☐

Personal Details			
First Name:		Surname:	
Preferred name:			
Occupation/Qualification:			
Address:			
Phone:		Email:	
National Registration Number:		EXP:	
Authorising Body:			
Copy of Registration attached?	YES / NO		

NOK/Emergency Information			
Name:		Relationship:	
Phone:		Mobile:	
Address:			

Business/Organisational Details			
Company/Organisation Name:			
Occupation:		ABN:	
Business Address:			
Phone:		Fax:	
Email:		Provider #	

Professional Indemnity Insurance			
Insurance Provider		Member number	
Category of Coverage:			

Does your membership fully cover the scope of clinical practice you are applying for?	YES / NO
Do you have any current claims against you?	YES / NO
Copy of Professional Indemnity Insurance attached?	YES / NO

Confirmation & Agreement	
I agree to always maintain client privacy and confidentiality.	YES / NO
I agree to work within The Toowoomba Hospice Clinical Framework.	YES / NO
I agree to work within my professional Scope of Practice.	YES / NO
I agree to disclose any concerns or discretions that may affect my ability to work with Toowoomba Hospice.	YES / NO
I agree to maintain my registration where applicable	YES / NO
I agree to provide care within Toowoomba Hospice only with client consent.	YES / NO
The information provided within this application is true and correct.	YES / NO

Signature of Applicant: ______________________________ Date: ____/____/20____

Signature of Director of Nursing: ______________________ Date: ____/____/20____