TOOWOOMBA HOSPICE

Private and Confidential

Application for appointment and scope of clinical practice as an accredited practitioner

New Application ☐	Renewal ☐

PLEASE PRINT OR TYPE, TICK RELEVANT BOXES, AND SIGN ON PAGE 4.

PLEASE RETURN THE FORM WITH A COPY OF YOUR REGISTRATION AND PROFESSIONAL INDEMNITY TO:

Chair Medical Advisory Committee, Toowoomba Hospice

Email: admin@toowoombahospice.org.au Facsimile: 07 4659 8511

PERSONAL AND CONTACT INFORMATION			
Surname		Given Names	
Preferred Title (e.g., Dr, Mr, A/Prof; Prof)		Preferred Name	
Any former names, including maiden name		Date of Birth	
Home Address ✉ preferred mailing address ☐	Post Code	Phone (home)	
		Mobile Phone	
Email (business)		Facsimile	
Emergency Contact Person		Relationship	
Phone (work) Phone (mobile)		Phone (home)	

PROFESSIONAL PRACTICE DETAILS			
Practice Name			
Business Address (Primary Consulting Room) ✉ preferred mailing address ☐	Post Code	Phone	
		Facsimile	

NATIONAL REGISTRATION DETAILS (Please attach copy of your Registration certificate)			
Registration Number		Expiry Date	
Category of Registration			

Are there any conditions or undertakings attached to this registration? Yes ☐ No ☐

If yes, please give details.

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Provider Number		Prescriber Number	

Have you ever been subject to an adverse finding or had conditions or undertakings attached to your registration by a medical board/dental board (as appropriate)? Yes ☐ No ☐

If yes, please give details of the restriction and what period during which the restrictions apply/applied.

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PROFESSIONAL INDEMNITY

(Please attach copy of your professional indemnity certificate or completed authority for your relevant indemnity provider)

Indemnity Insurance Number		Category of Coverage	
Insurance Company			

Does your membership fully cover the scope of clinical practice you have applied for? Yes ❑ No ❑

Has your medical defence union or any medical defence union or fund of which you have been a member ever applied conditions or refused to renew your cover or membership? Yes ❑ No ❑
If yes, please provide details.

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Are there any current claims against you with your Insurer or the Australian Health Practitioner Regulation Agency? Yes ❑ No ❑

If yes, please provide details.

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Have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance/medical laws, professional misconduct, sexual assaults or assault) by the Health Insurance Commission, Australian Health Practitioner Regulation Agency, a Health Care Complaints Commission/Body, a Coroner, a Court or any other professional, disciplinary or similar body? Yes ❑ No ❑

Criminal Record Check – Have you been convicted of, or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)? Yes ❑ No ❑

If yes, and if not prevented by confidentiality agreements, could you please provide a brief description of each adverse judgement or settlement, and the year in the event occurred?

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* This information is required to assess an application for scope of clinical practice and will only be used by Toowoomba Hospice for such purposes. Information provided will not be disclosed otherwise.

Medical Practitioner Emergency Contact

Please nominate a Medical Practitioner currently credentialed at Toowoomba Hospice who is available for contact by the Toowoomba Hospice in the case of an emergency if you are unavailable, and who has agreed to deputise for you.

Name	
Specialty	
Contact Number	

POSTGRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS, COLLEGE OR PROFESSIONAL QUALIFICATIONS

Qualification	Date Obtained	Accredited Training Organisation

PROFESSIONAL DEVELOPMENT OVER PAST 5 YEARS

(Please include any research activities, funded projects and quality assurance activity or attach copy of continuing Professional Development attendance)

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CURRENT HOSPITAL APPOINTMENTS

Hospital	Scope of Practice

Have you been refused clinical privileges at another health care facility?

Yes ☐ No ☐

If yes, please provide the name of the facility and rationale for refusal. *Please note a representative of the Toowoomba Hospice Credentials and Clinical Privileges Committee may contact the facility.*

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Has your scope of clinical practice 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 yes, please give dates and particulars. *Please note a representative of the Toowoomba Hospice Credentials and Clinical Privileges Committee.*

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ADMITTING RIGHTS SOUGHT AT THE TOOWOOMBA HOSPICE IN THE FOLLOWING CATEGORY(S) (Please tick)

- ☐ **Specialist Practitioner**
- ☐ **General Practitioner**

DETAIL THE SCOPE OF CLINICAL PRACTICE REQUESTED AT THE TOOWOOMBA HOSPICE

- ☐ **Palliative Care**

REFEREES – for new applications only

Please provide names, addresses, telephone numbers, email addresses, and facsimile numbers of three (3) professional referees (at least one from your own profession) who can attest to your recent practice and have known you for at least 12 months within the past 3 years. We prefer (where possible) that these referees are independent. However, where there is a relationship which may lead to a bias, such as a referee and the applicant are in business together as a partnership, or are employer/employee, then this relationship must be disclosed by you to the Toowoomba Hospice. Please note that your referees will be contacted and asked to provide a reference. The reference should be in writing.

Specialty		
(Referee 1) Name		
Email Address		
Phone		Facsimile
Address		
(Referee 2) Name		
Email Address		
Phone		Facsimile
Address		
(Referee 3) Name		
Email Address		
Phone		Facsimile
Address		

DECLARATION AND AUTHORITY

I am applying for admitting rights as a Medical Practitioner at the Toowoomba Hospice within the scope of practice of palliative care.

I authorise the Toowoomba Hospice and the Medical Advisory Sub-Committee, to obtain information on an annual, or as necessary, basis from Australian Health Practitioner Regulation Agency and my indemnity insurer as nominated in this application, regarding the currency of my registration and indemnity insurance.

I authorise the Toowoomba Hospice to include my contact details in their internal directory.

I agree to notify the Director of Nursing if I am convicted of a sex or violence offence or any other offence relevant to my practice as a Medical Practitioner.

I authorise the Toowoomba Hospice and the Medical Advisory Sub-Committee to verify with relevant individuals, external organisations, and nominated referees the validity of all claims made, including explicit consent for the organisation to verify my declaration regarding health status, professional registration history, claims, and legal proceedings.

I declare that I have no physical or mental condition or substance abuse problem that could affect my ability to exercise the scope of clinical practice requested or that would require any special assistance in order to enable me to exercise that scope of clinical practice safely and competently. I undertake to notify the Toowoomba Hospice if this statement becomes incorrect in the future.

I declare that my medical indemnity cover is adequate and appropriate for admitting privileges and activity which is the subject of this application.

I declare that I am the person named in this application and that the information provided by me in this application and in connection with this application is accurate and complete and is not misleading or deceiving or likely to mislead or deceive. I understand that if I have provided misleading or deceptive information, or information which is likely to mislead or deceive, that the Toowoomba Hospice Management Committee may (in its absolute discretion) consider that I do not have 'current fitness' under the Toowoomba Hospice policies and procedures.

I undertake to notify the Toowoomba Hospice promptly and in writing, if my scope of clinical practice is altered at any other hospital or day procedure centre.

I agree to participate in any clinical quality assurance activity including submitting my practice for clinical audit and peer review, to Toowoomba Hospice and the Medical Advisory Sub-Committee if required.

I undertake to notify Toowoomba Hospice should any information provided in this application for appointment vary in any way.

I acknowledge and agree to release Toowoomba Hospice from and against all claims out of a decision to suspend or terminate my accreditation or to not re-appoint me in circumstances decided by the Medical Advisory Sub-Committee and Management Committee.

In the event of myself or the aforementioned practitioner(s) being unavailable in the case of an emergency, I am agreeable to Toowoomba Hospice seeking urgent alternative assistance with authority to be exercised only after consultation with the Director of Nursing or delegate.

I understand that my admitting rights will be reviewed in five (5) years or earlier if considered necessary.

SIGNATURE ______________________________ DATE ____ / ____ / 20____

WITNESS NAME ______________________________ WITNESS SIGNATURE ______________________________

DATE ____ / ____ / 20____

NOTE: COPIES OF THE FOLLOWING MUST ACCOMPANY THIS APPLICATION:

- ☐ **EVIDENCE OF PARTICIPATION IN CONTINUING MEDICAL EDUCATION**
- ☐ **PROOF OF REGISTRATION**
- ☐ **PROFESSIONAL INDEMNITY – CERTIFICATE OF CURRENCY**