ESSENDON
PRIVATE CLINIC
Excellent Mental Health care in the Northwest

APPLICATION FOR CLINICAL PRIVILEGES

This document has been formatted to comply with the requirements of Safer Care Victoria: Credentialling and Scope of Clinical Practice for Senior Medical Practitioners Policy 2017

New application ☐	Renewal/re-application ☐	Altered scope of practice ☐

Name of medical practitioner

Surname						
First Name				Middle Name		
Dr. ☐	Prof. ☐	Mr. ☐	Mrs. ☐	Ms. ☐	Miss. ☐	Other. ☐

1. Scope of Clinical Privileges

I hereby apply for Clinical Privileges for the category and privileges indicated. To support my application I submit the following information (**Please print** and attach separate sheets if insufficient space):

Category of Specialist / Proceduralist	please tick applicable boxes for **Privileges**
ECT	☐
TMS	☐
Psychiatry	☐
Anaesthetic Privileges	☐
Other:	☐
Speciality In which appointment is sought	
Clinical Privileges Requested – specify areas of practice where clinical privileges are sought & details of any subspecialty or procedures you wish to undertake	

Please note: If you need to correct any error in your application, please initial the correction.

2. Applicant contact details

Surname			
Given Names			
Previous Name/s			
Date of Birth			
Place of Birth			
Residency Status (only applicable for initial Application or if there is an Altered Scope of Practice since last application at this service)		Australian Citizen ☐ Permanent Resident ☐ Temporary Resident ☐	
Professional address	Postcode State		
Postal address (if different to professional address above)	Postcode State		
Phone (BH)		Phone (AH)	
Mobile Ph		Email Address	
Do you have a Medicare Number for use at this location? Yes ☐ No ☐ Provider Number :		Do you have a Prescriber Number? Yes ☐ No ☐ Prescriber Number :	

3. 100 Point Proof of ID

Please attach 100 point proof of ID to your application. (See verification details attached)

4. Qualifications – Please attach a certified copy of the Original Document/s

Degree/Fellowship	Conferring Body	Year

5. Specialist Qualifications – Please attach a certified copy of the Original Document/s

Degree/Fellowship	Conferring Body	Year

6. Procedural Qualifications – Please attach a certified copy of the Original Document/s

Degree/Fellowship	Conferring Body	Year

7. Details of membership of Professional Associations

8. Current Appointments

FACILITY	APPOINTMENT

9. Past Appointments

FACILITY	APPOINTMENT

10. Referees

Please list the details of the referees attached to this document on the Professional Reference Request Form that was provided to you.

a) I authorise Essendon Private Clinic to seek information from my referees as to my past experience, performance and current fitness to practice.

b) Please provide details below for two peer references who can attest recent practice is consistent with the

criteria contained within the EPC By-Laws and are not professionally or financially related to the applicant. The referees provided should be familiar with your current professional capabilities.

Name	Address	Phone Number	Email address

11. Medical registration and other matters

Please refer to http://www.medicalboard.gov.au/ for definitions.

What is your Medical Board of Australia registration number?	
Is this general registration?	Yes ☐ No ☐
Is this provisional or limited registration? (if yes, provide details below)	Yes ☐ No ☐
Details:	
Do you have evidence of current compliance with maintenance of all the Professional Standards requirements as determined by the speciality colleges? If so please attach evidence of this	Yes ☐ No ☐

12. Medical indemnity insurance information

Current private medical indemnity insurance cover (if applicable Please attach a copy of current policy renewal form	Name of Insurer ……. …… Policy number …….
Does this insurance cover the requested scope of practice?	Yes ☐ No ☐

13. Agreement/undertakings

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

New applications only

I understand the health service will conduct a routine criminal history check in relation to my current and previous place/s of residence	YES ☐ NO ☐

New appointments and expanding scope of practice only

I authorise the health service to seek information from my referees as to my past experience, performance and current fitness to practice/	YES ☐ NO ☐

All applications

I accept that the health service will obtain information relevant to my application from the Medical Board of Australia and any other board regulating health practitioners, whether in Victoria or elsewhere	YES ☐	NO ☐
I authorise the health service to obtain information relevant to my application from my current and any previous medical indemnity organisation/insurer.	YES ☐	NO ☐
I agree to abide by the organisation's and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment	YES ☐	NO ☐
I agree to promptly notify the director of medical services/medical leader/Clinical Services Manager of any adverse clinical incident I am involved in, or become aware of.	YES ☐	NO ☐
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me	YES ☐	NO ☐

Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant …… Date ……

Please note: the information collected on this form will be used by the **Essendon Private Clinic** Credentialling and Scope of Clinical Practice Committee(s) to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

The **Essendon Private Clinic** operates in accordance with federal and state privacy legislation, including adherence to the National Privacy Principles. Copies of the **Essendon Private Clinic** Privacy and Confidentiality are available upon request.

Administration Use Only

Item	Checked/Sighted - Comments
1. Proof of Identification	☐
2. Contact details provided	☐
3. Provider Number	☐
4. Prescriber Number	☐
5. Qualifications (Originals or certified copies provided)	☐
6. Specialist Qualifications (Originals or certified copies provided)	☐
7. Procedural Qualifications (Originals or certified copies provided)	☐
8. Evidence of maintenance of standards	☐
9. Medical Registration Number	☐
10. Medical Indemnity Currency	☐
11. Referees (if required **)	☐
12. Declaration signed	☐

** Not required for reappointment at the same Health Service with **no change** in Scope of Practice

Other comments:

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Application details checked by (name) ……

Signature …… Date ……

Letter to applicant advising outcome of application Yes ❑ Copy attached ❑