PRESMED AUSTRALIA (PMA)

PRESMED AUSTRALIA
• EPPING SURGERY CENTRE
• CENTRAL COAST DAY HOSPITAL
• CHATSWOOD PRIVATE HOSPITAL

APPLICATION FOR APPOINTMENT AS AN ACCREDITED PRACTITIONER – INITIAL OR RE-ACCREDITATION

☐ Chatswood Private Hospital ☐ Epping Surgery Centre ☐ Central Coast Day Hospital
Please tick facility

PLEASE ENSURE THIS FORM IS FULLY COMPLETED AND THE FOLLOWING DOCUMENTATION IS INCLUDED WITH THIS APPLICATION:

Separate CV Attached ***(please note your CV will be forwarded to the Medical Advisory & Audit Committee at the PMA Facility you are applying to, who will be asked to provide a recommendation regarding your application).***

- **Copy of Post Graduate Qualifications**
- **Copy of College Fellowship**
- **Copy of certificate showing participation in Continued Medical Education**
- **Copy of current Medical Defence Organisation Membership**
- **Copy of current certificate of Medical Registration**
- **Copy of AHPRA restrictions (if applicable)**
- **100 Point Identification Check (Copy of Passport or Birth Certificate – 70 Points and Driver's Licence – 40 Points)**

1. CATEGORY AND SCOPE OF PRACTICE

I hereby apply to the PMA Facility/Facilities identified above for Appointment as an Accredited Practitioner and seek appointment for the Category and Scope of Practice indicated. To support my application I submit the following information (Please Print and attach separate sheets if insufficient space):

CATEGORIES	PLEASE TICK	SCOPE OF PRACTICE	PLEASE TICK
SPECIALIST PRACTITIONER		SURGICAL CARE	
SURGICAL ASSISTANT		ANAESTHESIA	
GENERAL PRACTITIONER		SURGICAL ASSISTING	
DENTIST		CONSULTING	
FELLOW PRACTITIONER		DIAGNOSTIC	
REGISTRAR		NON-SURGICAL CARE	
CONSULTANT EMERITUS			
STAFF SPECIALIST			
CAREER MEDICAL OFFICER			
OTHER			

Note: Surgeons are Specialist Practitioner (Categories) & Surgical Care (Scope of Practice). Anaesthetists are Specialist Practitioner (Categories) & Anaesthesia (Scope of Practice).

SPECIALTY	
SCOPE OF PRACTICE Specify areas of clinical practice applied for including specialty and sub-specialty qualifications and experience	
Anaesthetists electing to be accredited for paediatrics must nominate the age range/s below, qualifications/experience in paediatric anaesthesia and the frequency of paediatric lists at a Hospital providing children's services ☐ 28 days to 1 year ☐ 1 year to 2 years ☐ 2 years to 8 years ☐ 8 years to 14 years	Anaesthetists Please note which Surgeon/s you will be working with:

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2. PERSONAL DETAILS

NAME			
TITLE: (Dr, Mr, Prof, A/Prof)		SURNAME	
GIVEN NAME		ANY FORMER NAME INCLUDING MAIDEN NAME	
PRESCRIBER NO		PROVIDER NO.	
DATE OF BIRTH			

PERSONAL ADDRESS				
RESIDENTIAL ADDRESS			POSTCODE	
TELEPHONE		PAGER NO.		
FACSIMILE		MOBILE NO.		
EMAIL				

PRACTICE ADDRESS				
PRACTICE ADDRESS			POSTCODE	
POSTAL ADDRESS			POSTCODE	
TELEPHONE		FACSIMILE		
EMAIL				

3. QUALIFICATIONS (Please attach any relevant documentation)

DEGREE / FELLOWSHIP	CONFERRING BODY	YEAR

4. DETAILS OF MEMBERSHIP OF PROFESSIONAL ASSOCIATIONS

5. CURRENT APPOINTMENTS

FACILITY	APPOINTMENTS

6. PAST APPOINTMENTS

FACILITY	APPOINTMENTS

7. REFERENCES

Please provide details below for three professional references who can attest that your recent practice is consistent with the criteria contained within the PMA Facility Rules. Please refer to Rules 48 and 49.3. The referees provided should be familiar with your current professional capabilities.

Please note that your referees will be contacted and asked to provide a reference. The reference may be verbal or in writing.

Two referees must be from the area of your specialty. One referee must be a senior manager in a hospital or day procedure facility within which you have worked recently.

Referees are <u>not</u> required for <u>re-accreditation</u> applicants (every 5 years) unless otherwise requested by the Chief Executive Officer/Director.

1ST REFEREE		SPECIALTY/ POSITION/ FACILITY	
NAME		ADDRESS	
TEL / FAX NO.		EMAIL	

2ND REFEREE		SPECIALTY/ POSITION/ FACILITY	
NAME		ADDRESS	
TEL / FAX NO.		EMAIL	

3RD REFEREE		SPECIALTY/ POSITION/ FACILITY	
NAME		ADDRESS	
TEL / FAX NO.		EMAIL	

8. REGISTRATION

PLEASE SUPPLY DETAILS OF YOUR CURRENT REGISTRATION WITH AHPRA	
REGISTRATION NO	
SPECIALTY	
PLEASE ATTACH A COPY OF YOUR CURRENT REGISTRATION CERTIFICATE	

9. INSURANCE

Please refer to the PMA Facility Rules 'Initial Accreditation as a Medical Practitioner or Dentist' Rules 49.2 and 59.2.

Accredited Practitioners should have insurance cover from an Australian Insurer for $20m in any one claim and $20m for all claims in the aggregate.

Surgical Assistants should have insurance cover from an Australian Insurer for $10m.

If in doubt, please contact the Facility COO to discuss.

DO YOU HAVE CURRENT MEDICAL INDEMNITY INSURANCE AT THE APPROPRIATE LEVEL TO COVER YOUR SCOPE OF PRACTICE?	YES	NO
PLEASE ATTACH A COPY OF YOUR CURRENT MEDICAL INSURANCE / SCHEDULE		

10. PROFESSIONAL DEVELOPMENT

Please provide details (e.g. courses attended relevant to your appointment) of your compliance with the Continuing Education/Professional Development/Recertification or Maintenance of Standards Program of your College.

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11. DISCLOSURE

A	**Have you ever had any restrictions placed on your Medical Registration?**	YES	NO
(*If you answered yes to the above, please provide details (including details of the restriction and period during which the restrictions apply / applied):*			
B	**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 the COO may contact the facility)*			
C	**Has your Scope of Practice been restricted, suspended or not renewed on the basis of clinical competency at another hospital?**	YES	NO
(If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note the COO may contact the facility)			
D	**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, a medical 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)			
E	**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 you answered yes to the above, please provide details)			

NSW Applicants Only **- Working with Children**

A Working with Children Check is required of applicants in NSW who will be undertaking direct and unsupervised contact with children in the course of their work.

	YES	NO
Are you likely to be undertaking child related work meeting the definition above?		

	YES	NO
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? The COO or delegate will provide information on the Working with Children Check process.		

	REFERENCE NUMBER
If you have completed a Background Check within the last 5 years from another organization, please provide your Working With Children reference number for management verification.	

12. NOMINATION ALTERNATIVE IN EVENT OF EMERGENCY

In the event that I am unable to be contacted for a clinical emergency, the person nominated below is an appropriately qualified Accredited Practitioner who has agreed to deputise for me:	
NAME	
CONTACT PHONE NUMBERS	

13. CONFIRMATION:

I confirm that the information contained in this document is true and accurate 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 Board of the PMA Facility/Facilities at which I am applying to be accredited/accredited may (in its absolute discretion) consider that I do not have "Current Fitness" under the PMA Facility Rules.

I agree that I will notify the COO of the PMA Facility/Facilities at which I am accredited of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I understand that my Appointment as an Accredited Practitioner if granted will be reviewed at the end of the current quinquennium or earlier if considered necessary.

I acknowledge that I have been provided with and read a copy of the PMA Facility Rules. If appointed, I agree to abide by the PMA Facility Rules and policies of the facility at which I am accredited.

Signature:		Date:	
Witness Name:		Date:	
Witness Signature:			

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Medical Practitioner Authority to Release Information

I, _____, hereby authorise
(Insert Name)

(Please tick)

- ☐ AVANT
- ☐ MDA NATIONAL
- ☐ MiGA
- ☐ MIPS
- ☐ Other _____

N.B. Medical Board of Australia approved insurers only include these listed. If you have a different insurer you must provide evidence from AHPRA that this acceptable.

To provide confirmation of my indemnity insurance to PresMed Australia, Medical Administration.

My member number is: _____

My date of birth is: _____

The information provided may include the following details:

- Name
- Address
- Member ID
- Policy Number
- Policy start and end dates
- Policy limit
- Category of practice
- State of practice

This authority to release information is valid for the PresMed accreditation cycle 2016 – 2020.

Signed: _____

Date: _____

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FOR FACILITY USE ONLY

☐ Chatswood Private Hospital ☐ Epping Surgery Centre ☐ Central Coast Day Hospital

Please tick facility

Recommended by the Facility's Clinical Manager/Director of Nursing as delegate of the Chief Executive Officer/Director	☐ Yes	☐ No
Comments: (if applicable)…… ……		
Signature		Date

Recommended by the Facility's Medical Advisory & Audit Committee	☐ Yes	☐ No
Comments/conditions: (if applicable)…… …… ……		
Signature		Date

Accreditation Classification	**Tick**	**Scope of Clinical Practice**	**Tick**
Specialist Practitioner – (field) …… ……		Surgical Care	
General Practitioner		Anaesthesia	
Surgical Assistant		Surgical Assisting	
Dentist		Diagnostic	
Consultant Emeritus		Consulting	
Career Medical Officer		Non-surgical care	
Registrar			
Staff Specialist		For Anaesthesia: Age range ☐ **28 days to 1 year** ☐ **1 year to 2 years** ☐ **2 years to 8 years** ☐ **8 years to 14 years**	
Fellow Practitioner			

Recommended by Chief Executive Officer/Director	☐ Yes	☐ No
Comments/conditions: (if applicable)…… ……		
Signature	Date	

Recommended by the Board of the Facility above	☐ Yes	☐ No
Conditions/conditions: (if applicable)……-…… ……		
Approved by the Board of Directors of the Facility/Facilities identified above as evidenced by the letter sent on behalf of the Board confirming the appointment.	Date	