APPLICATION FOR ACCREDITATION

Application for accreditation as a Medical Practitioner

Please submit completed application form to:

City West Specialist Day Hospital
Chairman Medical Advisory Committee
30 Mons Road
Westmead NSW 2145

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, sign and complete Page 1and Page 2 (contact information) of this application. A copy of current indemnity insurance and registration must also be provided.

This is an application for my reappointment and there are no changes to the information required in Application for accreditation since I last applied.

_____ ____ / ____ / ____

Signature of Medical Practitioner **Date**

Surname of Applicant:	
First Names in full:	
Date of birth (optional):	
Accreditation category: (Please refer to page 3 for the list of category)	
Name of Partner or Spouse (optional - for hospital invitation list only):	

Please tick preferred mailing address:

☐ Residential Address with postcode: _____

_____

_____

Home Telephone:	Home Fax:

☐ Professional address with postcode: (Primary Consulting Room)	_____ _____ _____
Rooms Telephone:	Rooms Fax:
Mobile Number:	Provider No:
Email Address:	
Professional address (other consulting rooms):	
Undergraduate qualifications, university and year of graduation:	
Postgraduate qualifications, degrees, diplomas: (Attach CV if insufficient space)	
Year obtained: Qualification: Authorising Body:	Special comments on post graduate experience:
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Itemise Postgraduate Educational Activity in the past three years:
Nature of current practice, place of work and special professional interests:

Accreditation (Please tick):	
□ Permanent	□ Temporary from _____ to _____

Clinical privileges are sought in the field(s) of:

For each specialty in which you are seeking privileges, please provide names, addresses and telephone 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)

Specialty:		
Name of Referee 1:	Name of Referee 2:	Name of Referee 3:
Contact No. & postal address	Contact No. & postal address	Contact No. & postal address
Specialty:		
Name of Referee 1:	Name of Referee 2:	Name of Referee 3:
Contact No. & postal address	Contact No. & postal address	Contact No. & postal address

Please provide photocopy of your current registration		
Are there any conditions attached to this registration?	Yes □	No □
If Yes, provide details of conditions:		
Please provide photocopy of your Medical Defence Organistion or your Professional Indemnity Insurance Provider:		
Billing less than [insert amount and specialty]	$	
Does your membership fully cover the types of privileges you have applied for?	Yes □	No □
Appointment at other hospitals or day procedures centers:		
Current/past		
Current/past		
Current/past		
Membership of colleges and/or other relevant Associations:		
1. 2. 3. 4.		
Any additional information:		
Have your clinical privileges and/or appointment at any hospital or day procedure center ever been reduced, suspended or revoked or have you had conditions attached to that appointment for any reason?	Yes □	No □
If Yes, give dates and particulars:		

Anaesthetists need not nominate a doctor, but must acknowledge the requirement to stay on site at City West Specialist Day Hospital until their patients are conscious and safe.

Please nominate a medical practitioner accredited at the day hospital in your specialist available for contact in case of an emergency if you are unavailable:

Name:	
Specialty:	
Contact Numbers:	

Specialist Directory:

- I authorize the Day Hospital; to include my details in the Day Hospital Specialist Directory and other marketing activities. Yes ☐ No ☐

Authority:

- I hereby apply for accreditation at the City West Specialist day Hospital. I have specified with clinical privileges required.
- I declare that I am the person named in this application
- In making this application I acknowledge and agree:
  - I agree to be bound by the City West Specialist Day Hospital By-Laws, which are avaialable on site for inspection.
  - The day surgery executives, its officers and the medical advisory committee(s) may seek information about my past experience, clinical performance and current fitness.
  - I believe there is no further information to disclose which might otherwise prejudice my application for appointment
  - Anaesthetists acknowledge the requirement to stay at City West Specialist Day hospital until their patients are conscious and safe.

_____

Full Name

_____ _____ / _____ / _____

Signature **Date**

Note:

Evidence of Medical Defence Organisation and registration with the relevant state(s) Medical Board(s) must accompany this application.

Please note temporary accreditation is valid for 1 year and full accreditation is valid for 5 years.

OFFICE USE ONLY		
RECOMMENDATIONS OF MEDICAL/CLINICAL DIRECTORS		
☐ Temporary privileges recommended	From ___ /___ /___	To ___ / ___ / ___
☐ Full privileges recommended	From ___ /___ /___	To ___ / ___ / ___
☐ Privileges not granted		
Comments		
Medical Director Signature:		
APPOINTMENT CONFIRMED BY MAC		Date: