PRESMED AUSTRALIA (PMA)

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

Please tick facility

☐ CPH ☐ ESC ☐ CCDH – Erina ☐ CCDH – Tuggerah ☐ MDS ☐ MWS ☐ SPDS ☐ DEH

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

FOR RE-ACCREDITATION PLEASE COMPLETE ONLY SECTIONS 1- 2, 10-13 & PP 7-8.

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 Indemnity Insurance**
- **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 MEDICAL PRACTITIONER		SURGICAL PRIVILEGES	
DENTIST		INTERVENTIONALIST PRIVILEGES	
SURGICAL ASSISTANT – MEDICAL PRACTITIONER		ANAESTHETIC PRIVILEGES	
REGISTRAR		SURGICAL ASSIST PRIVILEGES – MEDICAL PRACTITIONER	
SURGICAL ASSISTANT – NON-MEDICAL PRACTITIONER		ASSISTING FOR:	
GENERAL MEDICAL PRACTITIONER		SURGICAL ASSIST PRIVILEGES – REGISTERED NURSE	
MEDICAL PRACTITIONER		ASSISTING FOR:	
CAREER MEDICAL OFFICER		ADMITTING PRIVILEGES	
CONSULTANT EMERITUS		CONSULTING PRIVILEGES	
STAFF SPECIALIST		PROCEDURAL PRIVILEGES	
FELLOW MEDICAL PRACTITIONER		DIAGNOSTIC PRIVILEGES	

Note: Surgeons are Specialist Practitioner (Categories) & Surgical Privileges (Scope of Practice). Interventionalists are Specialist Practitioner (Categories) & Interventionalist Privileges (Scope of Practice). Anaesthetists are Specialist Practitioner (Categories) & Anaesthetic Privileges (Scope of Practice).

SPECIALTY	
SCOPE OF PRACTICE Specify areas of clinical practice applied. CV to include 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 ☐ 1 year to 2 years ☐ 2 years to 8 years ☐ 8 years to 14 years	
Anaesthetists - *Please advise which Surgeon/s you will be working with:*	

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2. PERSONAL DETAILS

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

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

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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 By-Laws. 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.

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

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 CEO 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 accreditation 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 CEO 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 CEO 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)			
F	**Exposure Prone Procedures (EPP's) – EPPs are those procedures where there is potential for contact between the skin (usually finger or thumb) of the Health Care Worker (HCW) and sharp surgical instruments, needles or sharp tissues (splinters/ pieces of bone/tooth) in body cavities or in poorly visualised or confined body sites including the mouth. Procedures which lack these characteristics are unlikely to pose a risk of transmission of blood borne viruses from infected HCW to patient. A HCW WHO IS EITHER HEP C, HEP B OR HIV POSITIVE MUST NOT PERFORM EPP's. Are you intending to perform EPP's? If yes, refer below:**	**YES**	**NO**
	As a AMP who performs EPP I have taken appropriate steps to know my HIV, hepatitis b & C infective status and will follow the requirements of NSW Policy directive PD2005_162 HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected.		

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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 CEO 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, **at the facility in which I am applying for accreditation**, 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 By-Laws.

I agree that I will notify the CEO 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 By-Laws. I have completed:

- ☐ Insurance Authority to Release Information (Pg 7)
- ☐ Clinical Education Compliance Form (Pg 8)

If appointed, I agree to abide by the PMA By-Laws 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
- ☐ TEGO
- ☐ 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 is 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

If you change your insurance provider, please advise PresMed.

Signed: _____

Date: _____

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CLINICAL EDUCATION COMPLIANCE FORM

Dr _____

The following educational topics are mandatory training requirements under the National Safety and Quality Standards for all clinical workforce in Australian Hospitals. This includes Accredited Medical Practitioners (AMP).

- As part of the facilities Application for Accreditation process, the following self-directed learning educational information is provided on our website at https://www.presmed.com.au/our-doctors/ comprising:
    - Emergency Procedures:
        - Emergency Codes
        - Emergency Response Assessment
        - Malignant Hyperthermia
        - Evacuation
        - Power Failure
    - Cardio Pulmonary Resuscitation
    - Aseptic Technique
        - Hand Hygiene
    - Open Disclosure
    - Complaints
    - Patient Centred Care
    - Antimicrobial Utilisation

In addition to the Hospital's Board & Medical Advisory & Audit Committee endorsed:

- Patient Selection Protocol
- Approved Adult Procedures Policy
- Approved Paediatric Procedures Policy
- Approved Fasting and Medication Protocol

I have:

- Read and understand the AMP Education Pack Yes ☐ No ☐
- Read and understand the Approved Procedures & Patient Selection Protocol Yes ☐ No ☐

Sign:	Date:

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Recommended by the Facility's Clinical Manager/Director of Nursing as delegate of the Chief Executive Officer/Director	☐ Yes	☐ No
Comments: (if applicable)…… …… …… Date ……		
Signature	Date	
Recommended by the Facility's Medical Advisory & Audit Committee	☐ Yes	☐ No
Date Committee specialist representative members emailed: …… Comments/conditions: (if applicable)…… ……		
Signature	Date	

Accreditation Classification	**Tick**	**Scope of Clinical Practice**	**Tick**
Specialist Medical Practitioner – (field) …… ……		Surgical Privileges	
Dentist		Interventionalist Privileges	
Surgical Assistant – Medical Practitioner		Anaesthetic Privileges	
Surgical Assistant – Non-Medical Practitioner		Surgical Assist Privileges – Medical Practitioner	
Registrar		Surgical Assist Privileges – Registered Nurse	
General Medical Practitioner		Admitting Privileges	
Medical Practitioner		Consulting Privileges	
		Procedural Privileges	
Career Medical Officer		Diagnostic Privileges	
Consultant Emeritus		For Anaesthesia: Age range	
Staff Specialist		☐ 1 year to 2 years	
Fellow Medical Practitioner		☐ 2 years to 8 years ☐ 8 years to 14 years	

Recommended by Chief Executive Officer/Director	☐ Yes	☐ No
Comments/conditions: (if applicable)…… Temporary Accreditation Letter completed:…… ☐		
Signature	Date	
Recommended by the Medical Advisory & Audit Committee of the Facility above at its MAAC Meeting	☐ Yes	☐ No
Comments/conditions: (if applicable)……-…… ……		
Recommended by the Board of the Facility above at its Board meeting	☐ Yes	☐ No
Comments/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	