Virtus SPECIALIST DAY HOSPITALS
MEMBERS OF VIRTUS HEALTH

Credentialing Application Form

This application form allows for the collection of required information from medical practitioners who seek to be credentialed to practice at Virtus Specialist Day Hospital.

Please note the following:

1. We will accept scanned or hard copy credential applications and supporting documents.
2. The information collected on this form will be used by VSDH to assist in the determination of your application.
3. The information collected on this form will be stored on a secure VSDH database and will be subject to audits.
4. Information provided on this form will not be used or disclosed for any other purpose.
5. Virtus Specialist Day Hospitals operates in accordance with Federal and State Privacy Legislation including adherence to the National Privacy Principles.
6. A copy of the Virtus Specialist Day Hospitals Privacy Policy is available upon request.

APPLICATION CHECKLIST

- ☐ New application
- ☐ Re-accreditation

Please check that you have completed all sections in this application form and have provided the supporting evidence noted below, as well as additional supporting evidence if required. If you have any questions about the application or our requirements, please email *DH.credentialing@virtushealth.com.au*

- ☐ **Sign the Authorisation, Agreements and Declaration section on page 5 of this form**
- ☐ Copy of **professional registration**
- ☐ **Current Curriculum Vitae**
- ☐ Copy of **Specialist Qualification/s** (New applicants only)
- ☐ Copy of current **Medical Indemnity Insurance Certificate**
- ☐ Supply a minimum of 2 Professional Written References (attached)
- ☐ CPD Certification. Provide a copy of current college certificate, annual statement of participation or evidence of relevant continuing professional development.
- ☐ Working with Children's' Check (New applicants only)
- ☐ Police Check (New applicants only)
- ☐ **Vaccination Record** COVID Vaccination Certificate Consistent with Category A. Check list attached for your reference or alternatively see **The Australian Immunisation Handbook:** *www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home*
- ☐ **Basic Life Support Certification** within past 2 years (not required for Anaesthetists)
- ☐ Copy of current **Visa documents** if you are not an Australian Citizen (New applicants only)

Credentialing Application Form

1. Virtus Specialist Day Hospital Application Request:

Please nominate the hospital(s) you are requesting approval for admitting rights.

- ☐ Alexandria Specialist Day Hospital
- ☐ City West Specialist Day Hospital
- ☐ East Melbourne Specialist Day Hospital
- ☐ Hobart Specialist Day Hospital
- ☐ Mackay Specialist Day Hospital
- ☐ North Shore Specialist Day Hospital
- ☐ Spring Hill Specialist Day Hospital

2. Applicant's Information:

TITLE	FIRST NAME	MIDDLE NAME	SURNAME

Current Residential Address		Postcode
Primary Practice Address		Postcode
Email Address		
Phone (BH)	Phone (AH)	Mobile
Date of Birth	Gender: ☐ Female ☐ Male ☐ Other	
Emergency Contact Person	Name: Relation to you:	Mobile:

3. Qualifications: Primary Medical Degree. Please provide your current CV ONLY for re-accreditation.

QUALIFICATIONS	UNIVERSITY/ORGANISATION	YEAR OBTAINED
Primary Medical Degree		
Other degree(s)		

Details of professional memberships

Other specialty qualification/credentials including certifications for specific procedures

4. Scope of Practice

Please indicate below the core specialty for which you will be seeking to be credentialed:

- ☐ Anaesthetics
- ☐ Cosmetic Surgery
- ☐ Dental Assistant
- ☐ Endoscopy
- ☐ ENT
- ☐ General Surgery
- ☐ Opthalmology
- ☐ Oral Surgery
- ☐ Paediatric Dental
- ☐ Paediatric Surgery
- ☐ Plastic & Reconstructive Surgery
- ☐ Surgical Assistant
- ☐ Urology
- ☐ Other

If Other, please specify: .....

Have you met the continuing professional development requirements of the Medical Board of Australia? ☐ Yes ☐ No

Refer to AHPRA's registration standard for details at *www.medicalboard.gov.au/Registration-Standards.aspx*. Provide a copy of your current college certificate, annual statement of participation or evidence of relevant continuing professional development.

5. Important Registrations & Clearances

AHPRA Registration Number:	
NSW Working with Children number:	
Prescriber Number:	
Police Check	☐ Yes ☐ No
Are you currently registered as a medical practitioner in any other country? If yes, which country/s.	☐ Yes ☐ No
Have you ever been registered as a medical practitioner in any other country? If yes, which country/s.	☐ Yes ☐ No
Do any restrictions or conditions apply to any of the above? **Please explain below and / or attach full details if you answer 'Yes'**	☐ Yes ☐ No

6. Medical Indemnity Insurance Information

Current private medical indemnity insurance cover & signed authorisation. Please submit a copy of your current policy certificate

Have there ever been or are there currently pending medical indemnity claims, settlements or judgments against you?	☐ Yes ☐ No
Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	☐ Yes ☐ No

If the answer to either of the above two questions is YES, please provide a detailed explanation below and specify the name of the relevant medical defence organisation/insurer.

7. Discipline and other matters – Please refer to *www.ahpra.gov.au* for definitions.

Have you ever been formally disciplined by an employer or other organisation in the course of your work as a medical practitioner?	☐ Yes ☐ No
Have you ever been the subject of any prior disciplinary decisions or rulings imposed by any registration board in Australia or elsewhere?	☐ Yes ☐ No
Do you currently have or have ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country?	☐ Yes ☐ No
Have you ever been denied a scope of clinical practice that you requested?	☐ Yes ☐ No
Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	☐ Yes ☐ No
Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence?	☐ Yes ☐ No
Are you the subject of current or pending criminal charges?	☐ Yes ☐ No

If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'Confidential for Chairman of MAC only' appended to this application.
Indicate here that additional information is provided separately in this manner. ☐ Yes

8. Clinical Appointments (New applicants only)

Please provide details of all current and previous clinical appointments held within the last 2 years (including names of organisations and dates of appointment), or other places of practice (for example, general practice, other hospitals).

ORGANISATION	NAME AND TYPE OF APPOINTMENT	WHEN DID YOU WORK IN THAT ROLE?
		to
		to
		to
		to
		to

9. Health and support considerations

Do you have a disability/health issue(s) that: • may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application?	☐ Yes ☐ No
• may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?	☐ Yes ☐ No

If you answered YES, please provide details of the disability or health issue(s) and its likely or possible impact on your ability to practice. Details of any special equipment facilities or work practices required should be included.

This information can be provided on this form, or, alternately, you can provide the information in a sealed envelope marked "Confidential for Medical Director only" appended to this application.

Indicate here if additional information is being appended. ☐ Yes

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at VSDH or whether any reasonable adjustments might be required to ensure you can work at VSDH in a way that ensures patient safety.

10. Referees – (New applicants only) Please provide details of at least two referees:

Referee 1

Name		Current position	
Professional address			Postcode
Phone (BH)		Phone (Mobile)	
Email address			

Referee 2

Name		Current position	
Professional address			Postcode
Phone (BH)		Phone (Mobile)	
Email address			

Referee 3

Name		Current position	
Professional address			Postcode
Phone (BH)		Phone (Mobile)	
Email address			

11. Authorisation, Agreements and Declaration

1. **Authorise** VSDH to complete a range of enquiries to assess my suitability for appointment including:
   a. Obtaining information about my past experience, performance and current fitness to practice from my nominated referees;
   b. Verifying information relevant to my application from the Medical Board of Australia, AHPRA and any other authority that regulates health practitioners;
   c. Verifying that I hold current medical indemnity insurance at the level appropriate to my speciality;
   d. Seeking information from other persons or institutions as VSDH considers appropriate, including any relevant university, health service, college or other professional organisation;

2. **Agree** to act as follows upon being approved as a credentialed VSDH medical practitioner:
   a. I will familiarise myself with relevant by-laws, policies (including the VSDH Code of Conduct) and procedures and abide by them.
   b. I will abide by the organisation's and state and national confidentiality and privacy laws and policies (including the VSDH Code of Conduct) and understand that breaches may result in cessation of my appointment.
   c. I will notify the General Manager of any event/situation which may impact on my ability to practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the General Manager would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, or reductions in registration or insurance).
   d. I will participate in VSDH performance development and support processes.
   e. I will promptly notify the General Manger of any adverse clinical incident I am involved in or become aware of.

3. **I hereby declare that the information contained in this application is true and correct in every respect:**

Name (print or type):			
Signature of Applicant:		Date:	

If for any reason you are unable or unwilling to sign the above Authorisation, Agreement and Declaration statement, then please explain the circumstances in the space provided below.

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