APPLICATION FOR ACCREDITATION – MEDICAL PRACTITIONER OR DENTIST (INCLUDING SURGICAL ASSISTANTS)

Application for Accreditation **Application for Accreditation as a Medical Practitioner including Surgical Assistants or Dentist**	
Please submit completed application form to the General Manager at Canberra Private Hospital	
New Appointment Reappointment	
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 your contact details on this application.*** □ **This is an application for my reappointment and there are no changes to the information required in the 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/Spouse: *(optional - for hospital invitation list only)*	
Please tick ▭ preferred mailing address:	
Residential Address with postcode:	
Home Phone:	Home Fax:
Professional address with postcode (include PO Box): Primary Consulting Room	
Rooms Telephone:	Rooms Fax:
Pager Telephone:	Pager No:
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) Note: Certified copies of original qualifications should be obtained, if possible	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	
Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	

Hospital Appointments within last ten years:		
Dates:	Hospital:	Appointment:

Itemise Postgraduate Educational Activity in the past three years:
Nature of current practice, place of work and special professional interests:
Publications *(Please attach list or CV):*
Accreditation sought in the following category(s):
Specialist Practitioner General Practitioner Staff Specialist Dentist Dental Specialist Consultant Emeritus *(No admitting rights)* Consultant Specialist/General Practitioner *(No admitting rights)* House Medical Officer *(Resident, Registrar, Career Medical Officer)* Surgical Assistant *(No admitting rights)*
Registered speciality/sub-specialties:

Surgical Assistant applicants only: Name of accredited practitioner at each applicable hospital who will provide a reference for you.		
Name	Address & Phone	Hospital
Name	Address & Phone	Hospital
Name	Address & Phone	Hospital
Name	Address & Phone	Hospital
Name	Address & Phone	Hospital

Accreditation (Please tick):	
Permanent	Temporary from _____ to _____ <insert date> <insert date>

Field	Surgical Admitting	Medical Admitting	Consulting	Other (specify)

For each speciality 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:
Address:	Address:	Address:
Contact details:	Contact details:	Contact details:

Specialty:		
Name of Referee 1:	Name of Referee 2:	Name of Referee 3:
Address:	Address:	Address:
Contact details:	Contact details:	Contact details:
Email	Email	Email

Please record your current registration number with the relevant State Medical or Dental Board (as appropriate) and provide photocopy:

State(s):	Number(s):	
Are there any conditions attached to this registration?	Yes	No
If Yes, provide details of conditions:		

Please state the name of your Medical Defence Organisation or your Professional Indemnity Insurance Provider and provide photocopy:

Name:		
Membership Number:		
Category of membership: *(insert specialty) eg full surgeon*		
Billing less than $(insert amount) (insert specialty)		
Does your membership fully cover the types of privileges you have applied for?	Yes	No

Appointment at other hospitals or day procedures centres:

Current/past	
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 centre 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:		
Please nominate a medical practitioner accredited at the hospital in your specialty available for contact by the Hospital in case of an emergency if you are unavailable:		
Name:		
Specialty:		
Contact Numbers:		
Specialist Directory: ***(Not applicable to surgical assistants)***		
• **I authorise the Hospital to include my details in the Hospitals Specialist Directory Yes No**		
Authority**:**		
• **I hereby apply for accreditation at** *Canberra Private Hospital* **with clinical privileges I have also specified. • In making this application I acknowledge and agree: I have received a copy of the Canberra Private Hospital Pty Ltd By-Laws. I will abide by the By-Laws, as amended from time to time. The Hospital executives, its officers and the medical advisory committee may seek information about my past experience, clinical performance and current fitness. Signature: Date:**		
Note: Evidence of Medical Defence Organisation and registration with the relevant state(s) Medical Board(s) must accompany this application.		