THE SYDNEY PRIVATE HOSPITAL

ABN: 97 094 662 914

63 Victoria Street, ASHFIELD NSW 2131
Tel: (02) 9797 0555 Fax: (02) 9798 8561

APPLICATION FOR VISITING PRACTITIONER (VP) RIGHTS

1. **SPECIALTY RE-APPLYING FOR:**____

   1.1 PLEASE PROVIDE A LIST OF PROCEDURES YOU INTEND TO PERFORM. ***(ON A SEPARATE SHEET OF PAPER)***

2. **QUALIFICATIONS:**

   ____

   ____

3. **DATE OF APPLICATION:** ______________________

4. **FULL NAME:**______________________________ **DATE OF BIRTH:**_____________

5. **PRESCRIBER NO:**__________________ **PROVIDER NO.:**___________________

6. **PRESENT HOSPITAL APPOINTMENTS**

   Public: ____

   Other Hospitals to which you admit patients ______________________________________

7. **ADDRESS:**

   7.1 PROFESSIONAL:____

   ____

   POSTAL:____

   TELEPHONE:_______________________FAX:__________________________

   MOBILE:______________________________ PAGER:____________________

   EMAIL:____

   7.2 RESIDENTIAL: ____

   ________________________________TELEPHONE:______________________

8. **MEDICAL INDEMNITY INSURANCE:** **DATES OF COVERAGE:**________________
   (Please supply copy)

   8.1 HAVE THERE EVER BEEN OR ARE THERE CURRENTLY PENDING ANY CLAIMS, SETTLEMENTS OR JUDGEMENTS AGAINST YOU? YES / NO

   8.2 HAS YOUR MEDICAL DEFENCE ORGANISATION EVER EXCLUDED ANY SPECIFIC AREA OF PRACTICE, OR TERMINATED OR DENIED COVERAGE? YES / NO

   IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAIL OF EACH MATTER ON A SEPARATE SHEET AND ATTACH.

9. DISCIPLINARY ACTIONS:

9.1 HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY ACTION IN THE COURSE OF YOUR WORK AS A MEDICAL PRACTITIONER? YES / NO

9.2 HAVE YOU EVER BEEN CONVICTED OF ANY CRIMINAL CHARGES (OTHER THAN MOTOR VEHICLE OFFENCES)? YES / NO

9.3 HAVE YOU EVER BEEN CONVICTED OF A DRUG OR ALCOHOL RELATED OFFENCE? YES / NO

9.4 HAS YOUR ACCREDITATION EVER BEEN REVOKED FROM ANOTHER HOSPITAL?

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAIL OF EACH MATTER ON A SEPARATE SHEET AND ATTACH.

10. DETAILS OF REGISTRATION:

9.1 Initial Date of Registration in NSW ___ / ____ / ____ Registration No.______________
(Please supply copy)

11. WORKING WITH CHILDREN CLEARANCE CHECK?

Apply for your working with children check at
https://wwccheck.ccyp.nsw.gov.au/Applicants/Application#
(copy and paste this address into your address bar of internet explorer)

12. REFEREES: (please list the names of TWO (2) Medical Practitioners who will attest to this application. One referee must be in your specialty group.)

Surgical Assistants who require Accreditation for a short term (less than 6 Months) will only require a reference from the Surgeon they will be working with.

Name ___________________________________Position:_________________________________

Address: _____________________________________Phone:______________ Fax:___________

Name ___________________________________Position:_________________________________

Address: _____________________________________Phone:______________ Fax:___________

13. COPY OF ACCREDITED LASER CERTIFICATE YES NO N/A

14. COPY OF ACCREDITED RADIATION CERTIFICATE YES NO N/A

15. I AM AWARE THAT SHOULD THIS APPLICATION BE SUCCESSFUL THAT COMPLIANCE WITH THE RELEVANT BY-LAWS, OCCUPATIONAL HEALTH & SAFETY POLICIES AND RULES AND REGULATIONS OF THE SYDNEY PRIVATE HOSPITAL – ASHFIELD IN SO FAR AS THEY RELATE TO THIS POSITION, WOULD BE EXPECTED.

I AM AWARE THAT I MUST TAKE REASONABLE STEPS TO KNOW MY OWN INFECTIOUS DISEASE AND VACCINATION STATUS (AT MY OWN COST) AND MINIMISE THE RISK OF TRANSMITTING INFECTIOUS DISEASES.

A COPY OF THE BY-LAWS, RULES AND REGULATIONS WILL BE SUPPLIED WITH THIS APPLICATION.

16. I ACCEPT AND AGREE TO ABIDE BY THE CURRENT BY-LAWS POLICIES AND ALL REVISIONSISSUED AS NECESSARY BT THE SYDNEY PRIVATE HOSPITAL – ASHFIELD.

17. SIGNATURE OF APPLICANT:____

18. HOSPITAL USE ONLY:

18.1 References Checked: _______________

18.2 Registration checked:________________

18.3 Insurance checked: ________________

18.4 Working with Children Check: ________________

18.5 Relevant Education Certificates provided eg: laser: _______________________________

18.6 Radiation Licence provided: ____

18.7 Approved by Section Head: ________________________ Date: ____________________

18.8 Submitted to Medical Advisory Committee:______________________________________

18.9 Submitted to Board:____

18.10 Applicant notified:____

HOSPITAL / ADMIN USE ONLY:

19. RTA Check

Date Verified on Line	WWCC Number	Birth date	Expiry date