ARTARMON DAY SURGERY
1/448 Pacific Hwy, Artarmon NSW 2064
1300 559 848
www.artarmondaysurgery.com

VISITING MEDICAL PRACTITIONER ACCREDITATION APPLICATION FORM

PLEASE USE BLOCK LETTERS

Surname: First Name:

Practice Address:

Home Address:

Phone: (m) (h) (w)

Email Address:

ACADEMIC QUALIFICATIONS:

Include date and place of qualification; details of endorsement or accreditation by professional colleges, associations for the provision of specific clinical services, procedures or interventions.

	DEGREE	ISSUING BODY	YEAR
Initial			
Additional			

Has there been any change to your defined scope of clinical practice, or denial, suspension, conditions attached to your practice, termination or withdrawal of the right to practice (other than for organizational need and/or capability reasons) in any other organization?

NO **YES** *(please comment)*

Has there been any prior disciplinary action or professional sanction imposed by any registration board, Medicare, complaints body; criminal investigation or conviction; physical or mental condition or substance abuse problem (that could affect a medical practitioner's ability to exercise the requested scope of clinical practice)?

NO **YES** *(please comment)*

PROFESSIONAL ASSOCIATION MEMBERSHIP/S

Association	Type Membership

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CLINICAL PRIVILEGES REQUESTED:

□ Cosmetic/Plastic Surgical Procedures □ Anaesthesia (General Anaesthesia, Local, Sedation)

List procedures: ____________________

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MEDICAL REFERENCES:

(**New applicants only**. Please list Names, Current Position, Address and Phone Numbers of two (2) references).

1. ____________________

2. ____________________

You must provide:

- Evidence of current professional registration with AHPRA
- Evidence of type and scope of indemnity insurance policy
- Photocopy of passport or drivers licence (with photo)
- Current CV

This application will be submitted to the next meeting of the Medical Advisory Committee for due consideration.

- I hereby acknowledge that, if appointed, I agree to abide by the By-Laws (copy enclosed) and policies of Artarmon Day Surgery.
- I have received a copy of the Antimicrobial Stewardship, Open Disclosure and Admission and Exclusion policies.
- I am willing to support and participate in the quality improvement and risk management programs of the Clinic.
- I consent for the Clinic Manager and Medical Advisory Committee to verify with relevant individuals, external organizations and nominated referees the validity of all claims made.

____________________ ____________________

Signature of Applicant Date

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