



**RAMSAY**  
HEALTH CARE

**RAMSAY HEALTH CARE AUSTRALIA PTY LIMITED**  
ABN 36 003 184 889

**The Avenue Hospital**

## Application for Appointment as an Accredited Practitioner

### Practitioner Accreditation Form

### 1. Application for Appointment as an Accredited Practitioner

I hereby apply to Ramsay Health Care for Appointment as an Accredited Practitioner at The Avenue Hospital and seek appointment for the category and privileges indicated - *refer to Annexures D & E of the Hospital By-Laws*. To support my application I submit the following information (**Please Print** and attach separate sheets if insufficient space):

Categories	Please tick	Privileges	Please tick
Specialist Practitioner		Admitting Privileges	
General Practitioner		Consulting Privileges	
Staff Specialist		Assist Privileges	
Dentist		Anesthetic Privileges	
Consultant Emeritus		Surgical Privileges	
Fellow Practitioner		Diagnostic Privileges	
Other		Other	

<b>Specialty</b> in which appointment sought	
<b>Clinical Privileges Requested</b> (specify areas of practice where clinical privileges are sought & details of any subspecialty areas or procedures in which you wish to participate)	



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### 2. Personal Details

<b>Title</b> (eg: Dr, Mr, A/Prof, Prof)			
<b>Surname:</b>			
<b>Given Name(s):</b>			
<b>Any former names</b> (including maiden name)		<b>Prescriber No.:</b>	
		<b>Provider No.:</b>	

<b>Residential Address:</b>			
	<b>Postcode:</b>		
<b>Telephone:</b>		<b>Pager No.:</b>	
<b>Facsimile:</b>		<b>Mobile No.:</b>	
<b>Date of Birth:</b>			

<b>Practice Address:</b>			
	<b>Postcode:</b>		
<b>Telephone:</b>		<b>Facsimile:</b>	
<b>Email:</b>			



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### 2. Personal Details (continued)

Postal Address:	
	Postcode:

### 3. Qualifications

(Please attach any relevant documentation)

Degree/Fellowship	Conferring Body	Year

### 4. Details of Membership of Professional Associations


### 5. Current Appointments

Facility	Appointments



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### 6. Past Appointments

Facility	Appointments

### 7. References

Please provide details below for three peer references who can attest that your recent practice is consistent with the criteria contained within The Avenue Hospital By-laws.

We prefer (where possible) that these references are independent. However, where there is a relationship which can lead to a bias, such as a referee and the applicant are in business together as a partnership or are employer/employee, then this relationship must be disclosed by you to the hospital. 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 should be in writing.

Name	Address	Phone & Fax number



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### **8. Registration**

Please supply details of your current registration with the Medical Board of Victoria

**Registration Number:** .....

**Specialty:** .....

**Please attach a copy of the current Registration Certificate**

### **9. Insurance**

Please refer to Annexure K of The Avenue Hospital By-Laws "Ramsay Health Care Professional Indemnity Minimum Standards for Accredited Practitioners Guidelines as at January 2003".

Please note that by submitting this application you consent to a representative from Ramsay Health Care contacting your medical defense organisation / insurer to verify that you maintain appropriate medical indemnity coverage for the privileges sought.

Do you have current Medical Indemnity Insurance at the appropriate level?      Yes       No

Please provide details:

.....  
.....

**Please attach a copy of your Medical Insurance Policy / Schedule**



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### 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 what period during which the restrictions apply/applied):*

.....  
.....

b) Have you previously been refused clinical privileges 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, a senior executive of the hospital may contact the facility.*

.....  
.....

c) Have your clinical privileges ever been withdrawn, 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, a senior executive of the hospital 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:*

.....  
.....



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### **11. Disclosure (continued)**

- 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:*

.....

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.

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? Yes  No

### **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 who has agreed to deputise for me:

Name: .....

Contact Phone Numbers: .....



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### **13. Representation and warranty**

The information provided by me to Ramsay Health Care in this application and in connection with this application is accurate and complete 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 Ramsay Health Care Pty Limited may (in its absolute discretion) consider that I do not have "current fitness" under the Hospital By-laws.

I agree that I will notify the CEO of The Avenue Hospital 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 a Visiting Medical Officer if granted, will be reviewed in 5 years or earlier if considered necessary.

I acknowledge that I have been provided with, and, read a copy of the Hospital By-Laws. If appointed, I agree to abide by the policies and By-laws of The Avenue Hospital.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



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### **14. Consideration of Accredited Practitioner Application for Appointment Form**

**Recommended by Credentials Committee:**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Recommended by Medical Advisory Committee:**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Recommended by Chief Executive Officer:**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Approved by Ramsay Health Care Board of Directors**

**as evidenced by the letter sent on behalf of the Board      Date:** \_\_\_\_\_

**confirming the appointment, a copy of which is attached**

**Please ensure that this form is fully completed and that the following documentation is included with this application:**

- Separate CV Attached (*please note, your CV will be forwarded to the Medical Advisory Committee at The Avenue Hospital 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 Defense Society Membership.
- Copy of current certificate of Medical Registration.