KINGSGROVE DAY HOSPITAL

LEVEL 1, 322 KINGSGROVE ROAD
KINGSGROVE NSW 2208
PH: (02) 955 44 065
E: RECEPTION@KINGSGROVEDAYHOSPITAL.COM.AU

APPLICATION FOR APPOINTMENT AND CLINICAL PRIVILEGES

SURNAME OF APPLICANT:	PROVIDER NO:
CHRISTIAN NAME/S IN FULL:	WWCC NO:
DATE OF BIRTH:	APHRA NO:
RESIDENTIAL ADDRESS: *	
PROFESSIONAL ADDRESS:*	
TELEPHONE:	MOBILE NO:
EMAIL ADDRESS:	

UNIVERSITY AND YEAR OF GRADUATION		
Year Obtained	**Qualification**	**University**

POST GRADUATE QUALIFICATIONS, DEGREES, DIPLOMAS		
Year Obtained	**Qualification**	**Authorising Body**

IS THIS APPLICATION FOR YOUR INITIAL APPOINTMENT OR RE-APPOINTMENT? Initial / Reappointment

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DO YOU HAVE A CURRENT REGISTRATION WITH THE NSW MEDICAL BOARD? **Yes / No**
HAVE YOUR CLINICAL PRIVILEGES AND/OR APPOINTMENT AT ANY HOSPITAL OR DAY PROCEDURE CENTRE EVER BEEN REDUCED, SUSPENDED OR REVOKED FOR ANY REASON? **Yes / No**
DO YOU HAVE A CRIMINAL RECORD? **Yes / No**
ARE YOU THE SUBJECT OF OR HAVE YOU EVER BEEN SUBJECTED TO A MEDICAL BOARD INQUIRY RESULTING IN DISCIPLINARY ACTION OR RESTRICTION ON REGISTRATION? **Yes / No** If 'yes' please give dates and particulars:
FOR EACH SPECIALTY IN WHICH YOU ARE SEEKING PRIVILEGES, PLEASE PROVIDE NAMES, EMAIL AND TELEPHONE NUMBERS OF 3 PROFESSIONAL REFERREES IN AUSTRALIA (Not required for accreditation renewals):
WHAT OTHER FACILITIES ARE YOU CURRENTLY ACCREDITED AT?

SCOPE OF PRACTICE and TYPES AND RANGES OF PROCEDURES:	
Anaesthetics	Laser Surgery
Consultant Physician	Ophthalmology
Cosmetic Surgery	Orthopaedics
Dental Surgery	Paediatrician
Dermatology	Paediatric Anaesthetics
ENT Surgery	Paediatric Surgery
Gastroenterology	Plastic Surgery
General Surgery	Podiatry Surgery
Gynaecology	Urology
Laparoscopy (please specify)	OTHER:

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MEMBERSHIP OF LEARNED SOCIETIES (or attach copies):	
PLEASE DETAIL PRIVILEGES BEING SOUGHT WITHIN EACH FIELD	
Field	**Privileges Sought** (please tick)
	□ Administer sedation, intravenous infusion and local anaesthetic suitable to the patient and procedure to be carried out. □ Administer General Anaesthetics following the guidelines as specified by the Royal Australian College of Anaesthetists. □ Carry out surgical procedures in the specified field □ Assist with surgical procedures in the Operating Suites in specified field □ Other (please list):

I Declare that the statements contained in this Application are correct. In applying for appointment, I agree to abide by the By-Laws and Rules of the Kingsgrove Day Hospital, any terms and conditions that are attached to my appointment by the Board of Directors of its relevant committee. I authorise the DON of the Day Hospital and the Medical Advisory Committee to seek information to my experience, performance and current fitness. I agree to participate in the Visiting Practitioner Staff Committee. I have received and agree to abide by the Day Hospital's local policy and procedures. I am up to date with all immunisations as the Day Hospital's Staff Health and Safety Policy.

I HEREBY APPLY FOR APPOINTMENT or REAPPOINTMENT AT KINGSGROVE DAY HOSPITAL WITH PRIVILEGES SPECIFIED IN THE ABOVE FIELD.

DATE: **SIGNATURE:**

Note: *All new Accredited Practitioners are appointed for an initial twelve month period. A review is undertaken at the end of that period and subject to satisfactory outcomes the accreditation period is continued for the remaining two years.*
Applicants may be accredited for a period of up to three years and re-appointments can be renewed at the end of this period. All applications are submitted for temporary accreditation which will be formalised at the next credentialing meeting. ***Curriculum Vitae, Copy of Indemnity Insurance and Registration with the NSW Medical Board must accompany all new applications.***

Please return application to Kingsgrove Day Hospital, 1st Floor, 322 Kingsgrove Road, Kingsgrove NSW, 2208 or email:

reception@kingsgrovedayhospital.com.au or Facsimile: (02) 9554 8081. Any queries please call (02) 9554 4065.

References check by:

DON/ Practice Manager **APPLICATION APPROVED BY MEDICAL ADVISORY COMMITTEE**

SIGNATURE:..... **SIGNATURE**: .....

DATE : ..... DATE: .....