Application for Credentialing Registrar - 2018

Please note: if you need to correct any error in your application, please initial the correction.

Name of Medical Practitioner	
Family name:	
First name:	Middle name:
Previous name(s):	
This is a: New Application ☐	

Application Return

Please return completed application and additional documentation to:
Liz Caunt
Manager, Medical Workforce Unit
Albury Wodonga Health
PO Box 326
ALBURY NSW 2640
Email: liz.caunt@awh.org.au
All enquiries are to be directed to the Manager, Medical Workforce Unit (02) 60517543

Additional Documentation

Please include the following documentation with your application –

- Copy of current Medical Indemnity Insurance certificate (if applicable)
- Copies of relevant Visa documents (if applicable)
  Current CV (Signed copy)
- Certified copies of all specialist or other qualifications, other than a primary medical degree if these are not listed on the Medical Board of Australia website
- Proof of identification (100 point check)
- Copy of Working With Children Check Card
- Copy of National Police Check clearance
- Immunisation Records
- Criminal Statutory Declaration
- Privacy, Confidentiality & Security Agreements

SECTION 2 : Applicant Details					
Professional Address					
	City		State	Postcode	
Home Address (if different from above)					
	City		State	Postcode	
Mobile Telephone					
Email Address					
Date of Birth			Female ☐	Male ☐	
Place of Birth					
Residency Status	Australian Citizen ☐		Permanent Resident ☐	Temporary Resident ☐	
VISA Class			Visa Number		
Medicare	Wodonga Provider No.				
	Albury Provider No.				
	Prescriber No.				
Do restrictions reply to any of the above:	Yes ☐ No ☐		Details:		
Next of Kin / Emergency Contact Details					
Name					
Address					
Mobile Telephone					

SECTION 3: All qualifications including your primary medical degree		
Qualifications	**University / Organisation**	**Year Obtained**
Primary Degree		

SECTION 4 : Clinical appointments		
Please provide details of all current and previous clinical appointments held within the past five years (including names of organisations and dates of appointment)		
Organisation	**Name and type of appointment**	**When did you work in that role?**
		to
		to
		to
		to
		to
		to
		to
		to
		to
		to

SECTION 5 : Medical registration and other matters			
Please refer to www.medicalboard.gov.au for definitions			
Registration No.		Is this general registration	Yes ☐ No ☐
Is this limited registration?	Yes ☐ No ☐		
If yes, please specify			
If you have limited registration and/or you are to be supervised or under a college peer-review process, please provide details of this process			
Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a Medical Practitioner?			Yes ☐ No ☐
Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board either in Australia or elsewhere?			Yes ☐ No ☐
Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country?			Yes ☐ No ☐
Have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration either in Australia or elsewhere?			Yes ☐ No ☐
Has your right to practice ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?			Yes ☐ No ☐
Have you ever been convicted or found guilty or any criminal offence, including a drug or alcohol-related offence?			Yes ☐ No ☐
Are you the subject of current or pending criminal charges?			Yes ☐ No ☐
If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked "Confidential for Manager of Medical Workforce Unit Only" appended to this application and indicate here that additional information is provided separately in this manner.			
Additional information is provided separately in response to Section 7			Yes ☐ No ☐
Are you registered as a Medical Practitioner in any other country?			Yes ☐ No ☐
Have you ever been registered as a Medical Practitioner in any other country?			Yes ☐ No ☐
Do you have a current Working with Children Check?			Yes ☐ No ☐
If yes, please attach photocopy of current document / card	WWCC No.	Expiry:	

SECTION 6 : Medical Indemnity Insurance Information			
Name of current insurer			
Policy No.		Expiry date	
Have there ever been, or are there currently pending, medical indemnity claims, settlements or judgements against you?			Yes ☐ No ☐
Has your current or any previous medical defence organisation / insurer ever excluded or reduced any specific area of practice, or terminated			Yes ☐ No ☐
If the answer to either of the above two questions is Yes, please provide a detailed explanation and specify the name of the relevant medical defence organisation / insurer.			

SECTION 7 : Health Status	
Do you have a disability or health issue that:	
• May impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application	Yes ☐ No ☐
• May require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application	Yes ☐ No ☐
• May be relevant to determining your scope of practice	Yes ☐ No ☐
If you answered Yes, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included. *This information can be provided on this form or, alternatively, you can provide the information in a sealed envelope marked "Confidential for Director of Medical Services only" appended to this application. Indicate here if additional information is being appended.*	Yes ☐ No ☐
This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure you can work at the health service in a way that ensures patient safety.	

SECTION 8: Referees			
Please provide details of at least two referees who preferably work largely within the specialty being applied for, who have been in a position to judge your experience and performance during the previous three years and who have no conflict of interest in providing a reference.			
Referee 1			
Name			
Current Position			
Address			
	City	State	Postcode
Telephone (BH)		Years Known	
Email Address			

Referee 2			
Name			
Current Position			
Address			
	City	State	Postcode
Telephone (BH)		Years Known	
Email Address			

Referee 3			
Name			
Current Position			
Address			
	City	State	Postcode
Telephone (BH)		Years Known	
Email Address			

SECTION 9 : Agreements / undertakings	
I understand that in assessing my application for appointment as a Medical Practitioner, the health service will make additional enquiries as to my suitability for the position.	
I authorise the health service to seek information from my referees as to my past experience, performance and current fitness to practise.	Yes ☐ No ☐
I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them	Yes ☐ No ☐
I accept the health service will obtain information relevant to my application from the Medical Board of Australia and any other authority that regulates health practitioners	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my application from my current and previous medical indemnity organisation / insurer.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes ☐ No ☐
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes ☐ No ☐
I agree to abide by the organisation's and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes ☐ No ☐
I agree to notify the Director of Medical Services / medical leader of any event / situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to medical registration matters, or otherwise. This includes matters about which I consider that the Director / medical leader would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as criminal charges or convictions, or reductions in registration or insurance).	Yes ☐ No ☐
I agree to participate in this health service's performance development and support process.	Yes ☐ No ☐
I agree to promptly notify the Manager of Medical Workforce Unit / medical leader of any adverse clinical incident I am involved in, or become aware of.	Yes ☐ No ☐

SECTION 10 : Declaration		
I hereby declare that the information contained in this application is true and correct.		
Signature of application		Date signed

If for any reason you are unable to sign the Declaration above, please explain the circumstances.

Please note: the information collected on this form will be used by the Albury Wodonga Health to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

Albury Wodonga Health operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of Albury Wodonga Health's privacy and confidentiality policies are available upon request.

100 points – verification details

Any document not in English must be accompanied by an official translation by either the Community Relations Commission for a Multicultural NSW (formerly Ethnic Affairs Commission) or the Commonwealth Department of Immigration and Citizenship.

Type of check	Available points	Notes
Passport (current or expired by less than two years, not cancelled) Citizenship certificate (Australian only) Birth certificate (original or extract) Birth card issued by the Victorian or New South Wales Registry of Births, Deaths and Marriages.	70	Must contain name and a photo **Select one only**
Written reference Written reference from an acceptable referee from a financial institution	40	**Select one only.** Referee to have known the signatory for at least 12 months Both signatory and referee must sign the reference
Driver's licence. Renewed, interim, provisional, truck or learner's Other acceptable government-issued licences include boat, gun or pilot. Public Service Employee Identification Card Pension or government Health Care Card (reference number required) Identification card issued by a tertiary education institution	40 40 40 40 40	Must contain name, expiry date, a photo or signature
Letter from current employer (current or must have been employed by the employer within the past two years)	35	Must be on letterhead or company seal
Medicare card Overseas or international driver's licence or Proof of Age card	25 25	
Financial institution's credit card, cash card or passbook	25	Only one current card / passbook can be accepted
Rating authorities Rate notice (current). Provide the deposited plan (DP) number	35	
Public utility (water rate notice, electricity, gas or telephone account – no mobile accounts). Take a current notice with you.	25	
Statement from landlord, managing agent or owner of customer premises	25	Take letter, rental contract or rent receipt with you.