

Application for Appointment  
Registrar - 2019

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| **Name of Medical Practitioner** | |
| Family name: Click here to enter text. | |
| First name: Click here to enter text. | Middle name(s): Click here to enter text. |
| Previous name(s): Click here to enter text. | |
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| This is a: New Application | |
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| Position Applied for: Click here to enter text. | |
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| **Application Return** | |
| Please return completed application, covering letter and supporting documentation to:  Liz Caunt  Manager, Medical Workforce Unit  Albury Wodonga Health  PO Box 326  ALBURY NSW 2640  **Email:** [**liz.caunt@awh.org.au**](mailto:liz.caunt@awh.org.au)  All enquiries are to be directed to the Manager, Medical Workforce Unit (02) 60517543 | |
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| **Additional Documentation** | |
| **Please include the following documentation with your application –**   * Covering Letter * 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(s) * Copy of National Police Check clearance * Immunisation Records | |

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

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| **SECTION 3: All qualifications including your primary medical degree** | | |
| **Qualifications** | **University / Organisation** | **Year Obtained** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **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? (from – to)** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **SECTION 5 : Medical registration and other matters** | | | | | |
| Please refer to [www.medicalboard.gov.au](http://www.medicalboard.gov.au) for definitions | | | | | |
| Registration No. | Click here to enter text. | | Is this general registration | | Yes  No |
| Is this limited registration? | Yes  No | | | | |
| If yes, please specify | Click here to enter text. | | | | |
| **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 / cards for both Victoria and NSW (where applicable) | | WWCC No. Click here to enter text.  WWCC No. Click here to enter text. | | Expiry: Click here to enter text.  Expiry: Click here to enter text. | |

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| **SECTION 6 : Medical Indemnity Insurance Information** | | | | |
| Name of current insurer | Click here to enter text. | | | |
| Policy No. | Click here to enter text. | Expiry date | Click here to enter text. | |
| 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  or denied coverage? | | | | 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.*** | | | | |

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| **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.* | |

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| **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 | Click here to enter text. | | |
| Current Position | Click here to enter text. | | |
| Address | Click here to enter text. | | |
|  | City Click here to enter text. | State Click here to enter text. | Postcode Click here to enter text. |
| Telephone (BH) | Click here to enter text. | Years Known | Click here to enter text. |
| Email Address | Click here to enter text. | | |
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| **Referee 2** | | | |
| Name | Click here to enter text. | | |
| Current Position | Click here to enter text. | | |
| Address | Click here to enter text. | | |
|  | City Click here to enter text. | State Click here to enter text. | Postcode Click here to enter text. |
| Telephone (BH) | Click here to enter text. | Years Known | Click here to enter text. |
| Email Address | Click here to enter text. | | |
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| **Referee 3** | | | |
| Name | Click here to enter text. | | |
| Current Position | Click here to enter text. | | |
| Address | Click here to enter text. | | |
|  | City Click here to enter text. | State Click here to enter text. | Postcode Click here to enter text. |
| Telephone (BH) | Click here to enter text. | Years Known | Click here to enter text. |
| Email Address | Click here to enter text. | | |

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| **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 |

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| **SECTION 10 : Additional Information** |
| Please outline any other relevant information to support your application. |
| Click here to enter text. |

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| **SECTION 11 : Declaration** | | |
| I hereby declare that the information contained in this application is true and correct. | | |
| Signature of application |  | Date signed Click here to enter text. |
| **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.

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| **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. |