Application for Credentialling at Toowoomba Hospice – Accredited Practitioner

Please complete this form and return with a copy of your registration and professional indemnity insurance to: Chair Medical Advisory Credentials and Clinical Privileges Sub-Committee, Toowoomba Hospice via email: admin@toowoombahospice.org.au

New Application: ☐	**Renewal:** ☐

Admitting rights sought at the Toowoomba Hospice
☐ Nurse Practitioner
☐ General Practitioner
☐ Specialist Practitioner _____

Personal Details			
Surname			
Given Name/s			
Title		DOB	
Please note any previous names you have been known by (eg: Maiden name)			
Mailing Address *(practice or home address)*		Phone	
		Mobile	
		Fax mail	
Email			

Professional Practice Details			
Practice or business name			
Practice address		Phone	
		Mobile	
		Fax mail	
Mailing address *(If different from above)*			
Practice Email			

NOK or Emergency Contact Details			
Surname			
Given Name/s			
Title		Relationship	
Phone		Mobile	

Qualifications & Professional Development *(Please provide evidence of any qualifications)*		
Qualification/s	**University/Institution**	**Year Completed**

National Registration Details *(please attach a copy of registration certificates)*			
Registration Number		Expiry Date	
Category of Registration			
Are there any claims, adverse findings, conditions or undertakings attached to this registration? If yes, please provide details of restriction and what period they apply/ applied:			
Provider Number		Prescriber Number	

Professional Indemnity Insurance & Police Check *(please attach a copy of insurance certificates)* *This information is required to assess an application for scope of clinical practice and will only by Toowoomba Hospice for such purposes. No information provided will be disclosed otherwise.*			
Insurance Number		Expiry Date	
Category of coverage			
Insurance company			

Does your membership fully cover the scope of clinical practice you have applied for?	Select..
Has any medical union or fund you have been a member of ever applied conditions or refused to renew your cover or membership?	Select..
Are there any current claims against you with an insurer?	Select..

If you have noted any claims, adverse findings, conditions or undertakings attached to your insurance please provide details and what period they apply/applied:

Has there been any serious adverse findings (such as breach of medical or insurance laws, professional misconduct, sexual assault or assault) made against you by the Health Insurance Commission, Australian Health Practitioner Regulation Agency, any Health Care Complaints Commission/Body, a Coroner, a Court or any other professional disciplinary or similar body?

Select..

If yes, please provide details of same including the year the event occurred:

Criminal record check – Have you been convicted of, or pleaded guilty of a serious sexual or violent offence or an offence involving dishonesty or drugs (other than a spent conviction)?

Select..

If yes, please provide details of same including the year the event occurred:

Have you been denied clinical privileges at any other health care facility?

Select.. o applicant

If yes, please provide details of same including the year the event occurred. Please note a representative of the Medical Advisory Credentials and Clinical Privileges Sub-Committee may contact the facility for more information:

Has your scope of clinical practice and/or appointment at any other medical facility been reduced, suspended, revoked or have you had conditions attached to that appointment for any reason?

Select..

If yes, please provide details of same including the year the event occurred. Please note a representative of the Medical Advisory Credentials and Clinical Privileges Sub-Committee may contact the facility for more information:

Referees *(for new applications only)*

Please provide details for 3 professional referees, with at least one being from your own profession or speciality. Referees must be able to attest to your recent practice and have know you professionally for at least 12 months within the last 3 years. Please note any conflict of interest or partnerships for your referees that may impact their report (eg: business partners, employee/employer relationship etc). Your referees will be contacted and asked for a reference in writing.

Reference 1			
Title		Surname	
Given Name/s			
Email			
Phone		Mobile	
Relationship to applicant			

Reference 2			
Title		Surname	
Given Name/s			
Email			
Phone		Mobile	
Relationship to applicant			

Reference 3			
Title		Surname	
Given Name/s			
Email			
Phone		Mobile	
Relationship to applicant			

Applicant Endorsement and Declaration

Please note: In the event that you, the practitioner applying for clinical privileges at the Toowoomba Hospice, is not available to be contacted regarding the care of your client in an emergency, you (the practitioner) is agreeable to Toowoomba Hospice seeking urgent alternative assistance from a practitioner within the Medical Advisory Credentials and Clinical Privileges Sub-Committee with authority to be exercised only after consultation with he Director of Nursing or delegate.

I declare that all information provided in this application for credentialling and scope of practice at the Toowoomba Hospice is true and correct. I fully understand that any untrue, misleading or omitted information within this application constitutes cause for denial of privileges and termination of my contract.

I agree to comply with the conditions attached to this application for credentialling and scope of practice at the Toowoomba Hospice.

I also agree to abide by the policies and guidelines applicable to the Toowoomba Hospice, to which I am applying for scope of practice.

I consent to Toowoomba Hospice, obtaining any relevant information on past performance or any conditions or restrictions placed on my practice, including the nature of any unresolved complaints if relevant.

Additionally, I agree to notify the Toowoomba Hospice, promptly and in writing, of any changes to my registration or scope of clinical practice or, if there is any change to the information provided in this application.

I agree to release the Toowoomba Hospice from and against all claims out of a decision to suspend or terminate my accreditation or to not re-appoint me in circumstances decided by the Medical Advisory Credentials and Clinical Privileges Sub-Committee and Management Committee.

I understand that my admitting rights will be reviewed in five (5) years or earlier as required or considered necessary. At such time, I will provide the Toowoomba Hospice with updated documents and details relevant to re-application.

Full Name of Applicant			
Signature of Applicant		**Date**	
Full name of Witness			
Signature of Witness		**Date**	

Document Checklist: *Please ensure the following documents are provided with this application for credentialling.*

- ☐ **Credentialling application form (this form)**
- ☐ **Proof of Registration**
- ☐ **Professional Indemnity Insurance certificate**
- ☐ **Pre-employment immunisation screening tool**
- ☐ **Medicare provider number specific to the Toowoomba Hospice if applicable**