Reapplication for Clinical Privileges

CORPORATE/POSTAL
Westside Private Hospital
Level 3, Suite 311
32 Morrow St
Taringa Q 4068

PHONE 07 3833 6701
FAX 07 3833 6740

WESTSIDE PRIVATE
Level 1, 32 Morrow St
Taringa Q 4068

SAMFORD ROAD
383-391 Samford Rd
Gaythorne Q 4051

NORTH LAKES
7 Endeavour Blvd
North Lakes Q 4509

SUNSHINE COAST
10 King St
Buderim Q 4556

PATIENT BOOKINGS
& ENQUIRIES
PHONE 07 3833 6701

GP HOTLINE
PHONE 07 3833 6788

Dear Doctor

RE: REAPPLICATION FOR CLINICAL PRIVILEGES

Your Clinical Privileges at Montserrat are due to expire. To ensure you are certified
for practice at Montserrat it is essential that you confirm the details in the attached Reapplication and return to our office at your soonest convenience.

If you **DO NOT** intend to change your Scope of Practice, please confirm the details and sign the declaration form.

Alternatively, if you are altering your Scope of Practice you are required to complete **ALL** sections of the form including the Referee section. Please ensure that the referees are suitably qualified to comment on your clinical practice in the area of expertise that you are seeking.

If you no longer wish to hold privileges with Montserrat, please let our Credentialing Officer know via email, fax or phone on the details listed below. We can then remove you from our database and not continue to contact you regarding outstanding documents.

If you would like more information on the credentialing process at Montserrat Day Hospitals, or have a general enquiry, please contact our Credentialing Officer:

Email: montserratcredentialing@montserrat.com.au
Phone: 07 3833 6701
Fax: 07 3833 6740

We look forward to working with you at Montserrat Day Hospitals.

Yours sincerely,

Mr Ben Korst
CEO
Montserrat

Reapplication for Clinical Privileges

1. APPLICANTS DETAILS		
Montserrat holds the following details relating to your Credentials. If your details have changed, please provide the correct details in the amendment column.		
	Current Details	**Amendment Required**
Title:	Dr	
Surname:		
Given Name:		
Postal Address:		
Associated Organisation or Practice:		
Business Phone:		
Mobile Phone:		
Private Phone:		
Email Address:		
Fax:		
Preferred Method of correspondence:	Email	
Emergency Contact Name:		
Emergency Contact Phone:		
2. REGISTRATION		
Are there any current sanctions/restrictions imposed on your Medical Registration?	YES ☐ NO ☐	
3. INDEMNITY INSURANCE		
Do you have current Medical Indemnity Insurance at the appropriate level? (Attach)	YES ☐ NO ☐	
Insurance Company Name:		
Expiry Date of policy:		
Please Note: If you are insured with ***Avant***, please find attached at the back of this application, Authority for Montserrat to obtain your insurance information indefinitely.		
4. CLINICAL PRACTICE		
Scope of Practice		
Current Site of Practice	Indooroopilly (Now Westside Private Taringa), Samford Road, North Lakes	
Do you wish to extend your clinical practice to all MDH sites	YES ☐ NO ☐	
Do you wish to alter your scope of clinical practice?	YES ☐ *Proceed to section 5* NO ☐ *Proceed to section 7 (Do not complete section 5 or 6)*	

5. REFERENCES	***NOTE:* Only complete if altering scope of clinical practice**
#1	
Name:	
Current Position:	
Associated Organisation:	
Business phone no:	
Email address:	
#2	
Name:	
Current Position:	
Associated Organisation:	
Business phone no:	
Email address:	
#3	
Name:	
Current Position:	
Associated Organisation:	
Business phone no:	
Email address:	

6. SCOPE OF PRACTICE	***NOTE:* Only complete if altering scope of clinical practice**	
Anaesthesia ☐ Adults ☐ Paediatric* **Please attach evidence of training and currency of practice.* *How many lists performed in the past 12 months: _____*	**IVF, Obstetrics & Gynaecology** ☐ Gynaecology ☐ Uro-gynaecology ☐ IVF ☐ Other (Please detail)	**Gastroenterology**** ☐ Gastroenterology ☐ Colonoscopy ☐ Other (please detail) *** Must have Conjoint Committee Certification – Please attach*
Dental ☐ General Dental ☐ Paediatric	**ENT** ☐ Adult ☐ Paediatric	**Urology** ☐ Adult
Pathology ☐ Clinical Haematology	**General Surgery** ☐ Adult ☐ Paediatric ☐ Other (please detail)	**Orthopaedics** ☐ Adult ☐ Paediatric

7. **APPLICANTS DECLARATION** ***ALL*** *Applicant to complete*		
	TRUE	**FALSE**
	Please tick (✓)	*Please tick (✓)*
I have never been subject to an adverse finding or had conditions or undertakings attached to my registration and I am not currently under investigation. This may include 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.		
My right to practice and/or scope of clinical practice is not under investigation and/or has never been denied, restricted, suspended, terminated or otherwise modified in or by any other health care organisation (including overseas organisations, health facilities, learned colleges or other official bodies.		
I am not and have never been the subject of investigation by the Healt Rights Commission (HRC), Health Quality Complaints Commission (HQCC or other similar body interstate or overseas.		
A Medical Defence Union or Fund has never refused to renew my membership.		
I have not been subject to criminal investigation or conviction		
My clinical work is assessed by quality assurance mechanisms including clinical audit and peer review processes. I am not aware of any data from patient records, clinical audit, peer review processes or quality activities which reflects adversely on the outcomes of my clinical practice.		
I participate in the continuing medical education program, maintenance of professional standards program, or similar, of my College or Society and I am current with the requirements of that program.		
I agree to abide by the Policies and Standards of Montserrat Day Hospitals in regards to Privacy, Informed Consent (Financial and Clinical) and Open Disclosure.		
I have no physical or other conditions or substance abuse that may limit my ability to exercise the scope of practice which has been granted/requested		
I do not have any criminal charges pending against me.		
I have not been convicted of a criminal offence.		
Please comment below if you are unable to answer "True" to any of the above questions, and attach any relevant documentation		

8. **STATEMENT OF ACCEPTANCE** **ALL** *Applicants to complete and sign*

I, _____ authorise Montserrat to obtain information on an annual basis from the registration body as nominated in this application, regarding currency of my registration with that body or organisation. I will ensure that Montserrat s provided with current and valid evidence of membership with an Indemnity insurance organisation.
I authorise Montserrat Day Hospitals to contact my medical defence organisation/insurer to verify that I maintain appropriate medical indemnity coverage for privileges sought.
I authorise, if applicable, Montserrat to request a criminal history check be carried out on me.
I declare that the statements contained in this application are correct. In applying for appointment I agree to abide by Montserrat Day Hospital's policies and regulations and any terms or conditions which are attached to my appointment by the credentialing committee.
I undertake to immediately notify the Chair of Credentialing Committee of any material changes to the information provided by me in connection with this application, as soon as possible after the change, and particularly if my clinical Privileges are retracted, withdrawn or altered at any other hospital or day procedure facility.
I authorise Montserrat, its officers and agents to seek information as to my past experience, performance and current fitness and the validity of my responses to the above questions.
I understand that I will be granted Interim Clinical Privileges until I receive notification of Full Privileges following the next Credentialing Committee Meeting.
I am aware that I will have to complete a renewal of Clinical Privileges form when notified of the expiry of my privileges at Montserrat.
I understand that if I have provided misleading or deceptive information of information which is likely to mislead or deceive, that the Montserrat Board may (at its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.
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, procedures of the Hospital By-Laws

Signed:.....

Date: .....

Witness Signature: .....

Witness Name: .....

Authority to Release Information

Avant
mutual group

Avant Mutual Group Limited
ABN 58 123 154 898

Registered Office
Level 28 HSBC Centre
580 George Street Sydney NSW 2000

PO Box 746 Queen Victoria Building
Sydney NSW 1230

DX 11583 Sydney Downtown

www.avant.org.au

Telephone 02 9260 9000 Fax 02 9261 2921
Freecall 1800 128 268 Freefax 1800 228 268

I, _____
Avant Insured's Full Name

Avant Member ID: _____

hereby authorise Avant Insurance Limited (ACN 003 707 471) to provide confirmation of my indemnity insurance to the medical facility/ies(named in full) listed as follows:

Hospital Name	State

The information provided may include the following details:

- name
- address
- Avant member ID
- policy number
- policy start and end dates
- policy limit
- category of practice
- State of practice

This authority will continue until otherwise revoked in writing by myself.

Signed: _____ Date: _____
Avant Insured's Signature

This completed form should be returned to Avant Insurance Limited:

- by fax to 1800 228 268
- by mail to PO Box 746, Queen Victoria Building NSW 1230