

MEDICAL STAFF APPLICATION FORM

Royal Victorian Eye and Ear Hospital

Locked Bag 8, EAST MELBOURNE, VIC 8002. TEL +61 (03) 9929 8952, Fax + 61 (03) 9663 7203

1. Position Title				
2. Scope of Clinical Practice (SOCP) Sought (Refer Appendix 1)				
<input type="checkbox"/> .General/Medical	<input type="checkbox"/> 2.Specialist	<input type="checkbox"/> 3.Sub-Specialist (Please Specify)	<input type="checkbox"/> 4.Honorary	<input type="checkbox"/> 5.Other (Please Specify)
Where the SOCP sought for 3.(Sub-Specialist) varies from that listed, please detail and explain				
3. Personal Details				
Surname		Given Names		
Previous Name Please include your previous name if that appears on certificates				
Date of Birth		Place of Birth		
Residency Status		<input type="checkbox"/> Australian Citizen	<input type="checkbox"/> Permanent Resident (Please attach visa)	<input type="checkbox"/> Temporary Resident (Please attach visa)
Home Address				
		State	Country	Postcode
Pref. Address				
		State	Country	Postcode
Home Phone		Mobile Phone		
Work Phone		Fax No		
Email Address				
4. Qualifications (Undergraduate / Postgraduate / Formal recognised training for specialist qualifications) <i>Please provide copies of all qualifications obtained.</i>				
YEAR	QUALIFICATION	UNIVERSITY/ORGANISATION		
Fellowship date: __ / __ / ____ **please attach a certified copy of your Fellowship Certificate**				
5. Other Training and Clinical Experience (With respect to your response to Questions 1 and 2, please provide details of relevant clinical experience and post-qualification training. Include the title of course(s) undertaken, the organisation offering the course, and the qualification obtained)				
6. Clinical Appointments (Provide details on all current and previous clinical appointments, including names of organisations and dates of appointment, or other places of practice. eg general practice)				
APPOINTMENTS (Reverse chronological order)				

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FROM	TO	Organisation	Position Held (FT/PT)

Have you ever been denied a defined scope of clinical practice? Yes / No

Has your right to practise ever been withdrawn, suspended, terminated or reduced? Yes / No

If you answered YES to either of the above questions, please provide full details.

7. Summary of Clinical Activity undertaken over the previous 12 months

FROM	TO	DETAILS

8. Publications / Research Grants / Research Experience

DATE	DETAILS

9. Academic Appointments / Teaching Experience (Provide details of current and previous teaching appointments (including names of organisations and dates of appointment))

FROM	TO	ORGANISATION	STATUS/LEVEL

10. Management / Medical Leadership Experience (Hospital Committees, College Activities etc)

DATE	DETAILS

11. Current Medical Education / Continuing Professional Development (Please provide details of your involvement in current continuing medical education/continuing professional development. Include name of the college/organisation program in which you are enrolled and maintenance of activity log book)

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Have you satisfied the continuing medical education/continuing professional development requirements for your college membership/fellowship? Yes Please attach a copy of your current CME/CPD status No

12. Clinical Review / Peer Review

Do you regularly participate in formal quality and peer review activities? Yes / No

Provide details on such quality / peer review activities.

13. Have you any other information to support this application?

14. Regulatory and Indemnity Information

Medical Board of Australia Registration number (Please attach a copy of your registration certificate)

Is this registration temporary? Yes / No
If Yes, provide details

If you have registration pertaining to an area of need, please detail the type of assessment process undertaken prior to registration

Are you registered as a medical practitioner in another country? Yes / No
If so, please specify

If you have a specific registration and/or are required to undertake supervision, please provide details including name and location of supervisor and frequency of supervision

Do you have any conditions or restrictions placed on your registration? Yes / No
If so, please provide full details

In the past have you ever had any conditions or restrictions placed on your registration (either in Victoria or elsewhere)? If so, please provide full details Yes / No

Current medical indemnity cover ***Please attach a copy of current insurance policy, schedule or certificate of currency which details your field of practice (not a membership certificate or card)***

Is your proposed scope of clinical practice reflected in or covered by your current medical indemnity insurance? Yes / No

Have there ever been or are there currently pending any 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 any of the above is YES, please provide a detailed explanation (and specify the name of the relevant medical defence organisation/insurer).

Do you have a Provider number? If Yes, what is your number? Yes / No

If Yes, is it subject to any restrictions? Yes / No

If restrictions apply, please provide full details

Do you have a Prescriber number? If Yes, what is your number? Yes / No

Are you a registered specialist for the purposes of the payment of Medicare benefits to your patients? Yes / No

15. Health Status

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Do you have a disability / health issue that:

- May impact on your ability to perform any of the cognitive and physical functions which 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
- Might be relevant to determining your scope of practice? Yes / No

(In answering this question, please have regard to publications of the Medical Board of Australia, such as the Blood borne infectious diseases policy, which limits who may perform 'exposure prone procedures').

If YES, please provide details of the disability/health issue, its impact on your ability to carry out the scope of practice sought, and details of any special equipment facilities or work practices required.

This information can be provided on this form or, if you prefer, you can provide the information in a sealed envelope marked 'confidential for Chief Medical Officer only' appended to this application, and indicate here that additional information is provided separately in this manner.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent/reasonable requirements of the work which you seeking to perform at the hospital by submitting this application, or whether any reasonable adjustments might be required to ensure that you can work at the hospital in a way that ensures patient safety.

16. Disclosure About Disciplinary Actions / Criminal Activity

Have you ever been the subject of disciplinary action in the course of your work as a medical practitioner?

Yes / No

If YES, please describe.

Have you ever been the subject of prior disciplinary action or professional sanctions imposed by any registration board, hospital or health service (whether in Victoria or elsewhere)?

Yes / No

If YES, please describe.

Have you ever been the subject of any investigation, inquiry or findings by any registration board (whether in Victoria or elsewhere) in relation to your ability to practise or have direct patient contact, or regarding your professional performance or your professional conduct?

Yes / No

Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence?

Yes / No

Are you the subject of pending criminal charges?

Yes / No

If YES to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked 'confidential for Chief Medical Officer only' appended to this application, and indicate here that the additional information is provided separately in this manner.

Have you ever had any adverse findings made against you that may be relevant to your appointment (in addition to anything you may have noted above)?

Yes / No

If YES, please provide full details.

Have you applied for a Victorian Working with Children Check card?

Yes / No

NB: If successful, proof of your application or a copy of the card will be required prior to commencement.

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17. Referees

Please provide details of three independent professional referees, preferably at least two in your specialty, who have been in a position to judge your qualifications and experience during the past three years and who have no conflict of interest in providing a reference.

Referee 1	Name	
Position held currently		
Professional address		
Postcode		
Phone (BH)	Phone (Mobile)	Phone (BH)
Email address		

Referee 2	Name	
Position held currently		
Professional address		
Postcode		
Phone (BH)	Phone (Mobile)	Phone (BH)
Email address		

Referee 3	Name	
Position held currently		
Professional address		
Postcode		
Phone (BH)	Phone (Mobile)	Phone (BH)
Email address		

Agreement / Undertakings

I understand that in assessing my application for re-appointment as a visiting medical practitioner, the health service will make additional enquiries as to my suitability for the position. I authorise the health service to conduct a criminal history check in relation to my history. Yes / No

I authorise the health service to obtain information relevant to my application from the Medical Board of Australia or my learned College. Yes / No

I authorise the health service to obtain information relevant to my application from my current and any 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 as to my past experience, performance and current fitness from my referees and from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation. Yes / No

I authorise access to the above information by representatives of the health service's credentialing committees. Yes / No

If appointed, I agree to familiarise myself with relevant hospital by-laws, policies and procedures and to abide by them. Yes / No

If appointed, I agree to abide by confidentiality and privacy obligations and understand that breaches may result in the cessation of my appointment. Yes / No

I agree to notify the Chief Medical Officer / EDMA of any event/situation which 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 Chief Medical Officer / EDMA would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, reductions in registration or insurance). Yes / No

If appointed, I agree to comply with relevant ongoing educational/certification programs of my college/ association/joint consultative committee and to furnish details to the health service on an annual basis as requested by the Director of Medical Services/medical leader. Yes / No

If appointed, I agree to participate in annual performance appraisal. Yes / No

I agree to promptly notify the Director of Medical Services/medical leader of any adverse clinical incident I am involved in or become aware of. Yes / No

If appointed, I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me. Yes / No

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If appointed, should any question as to my credentialing or clinical practice arise, I agree that the health service may make such inquiries as it considers necessary to assess whether that credentialing or my scope of clinical practice is appropriate Yes / No

The Royal Victorian Eye and Ear Hospital is an Equal Opportunity Employer and aims to employ a workforce that reflects community diversity in a workplace free of discrimination and harassment.

I hereby declare that the information contained and declared in this application is true and correct, and I authorise The Royal Victorian Eye and Ear Hospital or its representatives to confirm the accuracy of any information supplied and to contact any previous employers and supervisors.

Signature of Applicant:

Date: / /

All applications will be considered by the RVEEH Medical Appointments and Credentialing Committee.

ATTACHMENTS REQUIRED:

All applications

CV/Resume	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Medical Board of Australia Registration Certificate	Yes <input type="checkbox"/> / No <input type="checkbox"/>
College CME/CPD statement/certificate	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Medical Indemnity Insurance Certificate	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Fellowship Certificate (certified)	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Working with Children Check card/receipt	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Visa (if applicable)	Yes <input type="checkbox"/> / No <input type="checkbox"/>

**Please return this form with required attachments to the Medical Workforce & Support Unit,
c/- Medical Services, RVEEH**

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Appendix 1 - Scope of Clinical Practice

The scope of clinical practice has been defined by the ACSQHC as involving the delineation of the extent of an individual medical practitioner's clinical practice within a particular organisation, based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice.

At RVEEH, the level of scope of practice is defined at four levels:

- *that expected of a medical practitioner;*
- *the range of clinical activities within a specialty that any appropriately trained medical practitioner would be expected to be competent to perform;*
- *the range of clinical activities within a subspecialty that any appropriately trained medical practitioner would be expected to be competent to perform; and,*
- *the management of emergencies and complications.*

Scope of Practice will be defined at the time of employment.