Clinical Credentialing Application - Medical

Please complete this form and return with the following documents to the Chief Executive Officer (CEO) via email CEO@fitzroyhospice.org.au

☐ Current Curriculum Vitae or Resume
☐ A Copy of your Passport (including Visa, if applicable)
☐ A Copy of your Driver's License (front and back)
☐ Copies of Relevant Qualifications, Registrations, Memberships
☐ Evidence of Current Professional Indemnity Insurance
☐ Completed Vaccine Preventable Diseases Evidence Form
☐ If applicable, Evidence of Current Credentialling at Mater Private Hospital Rockhampton, Hillcrest Rockhampton Private Hospital, or Central Queensland Hospital and Health Service

This information is required to assess your application for Credentialling and will only be used by Fitzroy Community Hospice (FCH) for this purpose. Under the FCH Privacy Procedure, we must not misuse any information entrusted to us. Confidential information is managed and stored in accordance with the FCH Privacy and Document Control Procedures.

Personal and Contact Information	
Surname	
Given Name(s)	
Preferred Name	
Former Names	
Date of Birth	
Residential Address	
Phone (Mobile)	
Email (Personal)	
ABN	
Prescriber Number	
Emergency Contact	
Name	
Relationship	
Phone (Mobile)	
Professional Practice Details (if applicable)	
Practice Name	
Practice Address	
Phone (Practice)	
Email (Practice)	

I am Applying for Credentialing within the Following Medical Scope of Practice:
☐ Specialist - General Practice
☐ Specialist - Palliative Medicine
☐ Specialist - Other:

References	
Please provide the details of two (2) referees who have known you for at least 12 months within the past 5 years and can attest to your recent practice. We prefer (where possible) that these referees are professional peers. Please note that your referees may be contacted by phone or email and asked to provide a reference.	
Referee 1	
Name	
Phone (Mobile)	
Email	
Relationship	
Referee 2	
Name	
Phone (Mobile)	
Email	
Relationship	

Registration Details	
AHPRA Registration Number	

Professional Indemnity Details	
Name of Insurer	
Policy Number	
Insured Value (AUD)	
Expiry Date	
Category of Coverage	

Declarations	
Do you have any matters currently before your registration board for investigation or consideration?	Yes ☐ No ☐
Do you currently have any conditions or restrictions placed on your registration or your clinical practice?	Yes ☐ No ☐
Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board?	Yes ☐ No ☐
In the past have you ever had any condition or restriction placed on your registration?	Yes ☐ No ☐
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 denied a scope of clinical practice that you requested?	Yes ☐ No ☐
Have you ever chosen to reduce your scope of practice?	Yes ☐ No ☐
Has your right to or scope of practice ever been withdrawn, suspended, terminated, restricted, or limited by an organisation, employer, or professional body?	Yes ☐ No ☐
Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence?	Yes ☐ No ☐
Do you have any criminal charges or convictions pending?	Yes ☐ No ☐
Is your proposed scope of clinical practice at Fitzroy Community Hospice covered by your current professional indemnity insurance?	Yes ☐ No ☐
Has your current or any previous indemnifier ever applied conditions or refused to cover or renew your indemnity cover?	Yes ☐ No ☐
Do you have any previous or current medical indemnity claims, settlements, or judgements against you?	Yes ☐ No ☐
Do you have any medical conditions which may limit your ability to exercise the scope of practice safely and competently being requested/granted?	Yes ☐ No ☐
If future circumstances change which would modify any of my above responses, I undertake to notify the CEO as soon as possible.	Yes ☐ No ☐
If yes to any of the above, please provide full details.	

Acknowledgements and Authorizations

I understand that in assessing my application, Fitzroy Community Hospice (FCH) may make additional enquiries as to my professional suitability, and that the granting of credentialling at FCH is subject to approval by the FCH Medical Advisory Group (in its absolute discretion).

I confirm that the information provided by me in this application is true and accurate and is not misleading, deceiving, or likely to mislead or deceive. I understand that if I have provided misleading or deceptive information, or information which is likely to mislead or deceive, that the FCH Board may (in its absolute discretion) withdraw granted credentialling, scope of practice, and/or admitting rights.

If Granted Credentialling -

- I authorize FCH to obtain information on an annual, or as necessary, basis from my registration board and professional indemnity insurance provider, as nominated in this application;
- I acknowledge that FCH may require me to undertake a National Police Check to meet applicable contractual, funding and governance requirements. I consent to FCH obtaining and using the results of the check for the purpose of credentialling and determining my suitability to provide services at FCH.
- I understand that recredentialling will be required after five (5) years, or earlier if considered necessary;
- I acknowledge and agree to release FCH from and against all claims out of a decision to suspend or terminate my credentialling or to not grant credentialing;
- If I am unable to be contacted in the case of an emergency or emergent clinical situation, I am agreeable to FCH Clinical Staff seeking alternative medical assistance for any inpatients admitted under me, with authority to be exercised only after consultation with the Clinical Services Manager or duly authorized person;
- I understand that if I provide care to Public Patients, FCH has a contractual obligation to disclose, in certain circumstances, elements of my Personal Information to Central Queensland Hospital and Health Service, and that if a need for this arises, I will be informed as such;
- I agree to abide by the FCH Code of Conduct and all FCH Governance Documents relevant to my practice as a Medical Practitioner. I understand that these documents will either be supplied as part of the induction process or be accessible on request, both now and into the future.

Name		**Signature**	
Date			