THE BAYS

APPLICATION FOR VISITING PRIVILEGES
ALLIED HEALTH

SURNAME: _____ **DATE:** _____

FIRST NAME(S): _____ **TITLE:** _____

DATE OF BIRTH: _____

SPECIALTY / DISCIPLINE(S): Allied Health

CONTACT DETAILS:

PROFESSIONAL ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ FAX: _____

MOBILE: _____

EMAIL:_____

PRIVATE ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ MOBILE:_____

EMAIL:_____

1. QUALIFICATIONS

GRADUATE		
Qualification	**Year Awarded**	**Reg Number**

POST GRADUATE		
Qualification	**Year Awarded**	**Reg Number**

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2. PROFESSIONAL REGISTRATION

ARE YOU REGISTERED TO PRACTICE IN AUSTRALIA? ☐ Yes ☐ No

CURRENT REGISTRATION NUMBER WITH THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY: _____

Please provide a copy of your AHPRA registration

3. PROFESSIONAL INDEMNITY INSURANCE

ARE YOU CURRENTLY INSURED? ☐ Yes ☐ No

NAME OF INSURANCE PROVIDER: _____

CERTIFICATE NUMBER: _____

Please attach a copy of your current certificate of insurance which indicates your level of cover

4. HOSPITAL APPOINTMENTS & REFERENCES

CURRENT PUBLIC HOSPITAL APPOINTMENTS: _____

_____

REFERENCES

List a referee who may be contacted: Referee should be from the applicant's discipline.

*To ensure impartiality, references will not be accepted from relatives/family of the applicant, exceptions apply in this instance and an alternative referee is to be supplied

REFEREE NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

EMAIL:_____

Please attach written reference if available

Are you willing to participate in the hospital Quality Management Program, Clinical Review and to comply with its findings, in order to maintain and improve hospital standards? ☐ Yes ☐ No

5. MEDICAL REGISTRATION STATUS / IDENTITY / SECURITY CHECK

Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked?	☐ Yes	☐ No
Do you have conditions attached to that appointment for any reason?	☐ 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 currently have any restrictions on your practice imposed by AHPRA?	☐ Yes	☐ No
Are you the subject of a current or pending AHPRA review or any criminal charges?	☐ Yes	☐ No

If you answered ***Yes*** to any of the above questions, please provide full details:

_____

_____

_____

_____

Or, if you prefer, provide the information in a sealed envelope marked '*Confidential for medical director only*' appended to this application, and indicate here that additional information is provided separately in this manner.

CERTIFIED 100 POINT IDENTIFICATION:

please circle those supplied, total must add up to 100 points minimum

Copies of all Primary Identification Documents and any other photo ID, i.e. Licences, must be certified copies

Documents must be certified by a person authorised as a witness for statutory declarations under *Statutory Declarations Regulations 1993* – Schedule 2. This includes persons who are currently licensed to practice as:

- a Legal Practitioner;
- a Medical Practitioner;
- a Chiropractor;
- a Dentist;
- a Nurse; or
- a Pharmacist.

The certifier must ensure that the copy to be certified is an identical copy of the original document. The certifier must state on the copied document that:

> *I certify that this is a true copy of the document produced to me on [**insert date**].*
> *Signature:*
> *Name:*
> *Qualification:*

For multiple page documents, the certifier must individually check each page of the copied document against the original. If the copied document is identical to the original document, the certifier must:

- sign or initial each page of the copied document; and
- certify the last page using the wording outlined above.

Primary Identification Documents - you are only allowed to use one of the following:

a.	Passport (current or expired within last two years, but not cancelled)	70 points#*
b.	Birth Certificate/Extract	70 points#*
c.	Citizenship Certificate	70 points#*

 # If you have changed your name from that on the document (e.g. due to marriage, etc.) the document cannot be accepted

Secondary Identification Documents - you may use several of the following to reach 100 points:

a. Documents which verify your identity by photograph and/or signature:

d.	Licence issued under Australian law (e.g. driver's Licence or other government issued licence) which contains a photograph or signature	40/25 points*
e.	Employee ID card issued by a Government Authority or Public Service	40/25 points*
f.	Social Security, Health Care or Pension card	40/25 points*
g.	Tertiary Education Institution ID card	40/25 points*

* *If you wish to use more than one document from this group, the first acceptable document scores 40 points, but subsequent documents only score 25 points each*

b. Documents which verify your full name and residential address:

h.	A utility bill (e.g. water, electricity, gas)	25 points
i.	A telephone bill or council rate notice	25 points
j.	Foreign driver's licence	25 points
k.	Medicare card	25 points
l.	A bank/credit union/building society passbook, statement or debit/credit card*	25 points

* *If you wish to count more than one bank document or card, each document MUST be issued by a different Financial Institution (FI). If documents are from the same FI, only one can be counted.*

6. DECLARATION & CHECKLIST

I _____

agree to abide by the By-Laws, Rules and Regulations of the Medical Staff of this hospital as adopted and amended from time to time.
I accept the Hospital Mission Statement, Philosophy, Policies and Procedures.
I agree to abide by the Code of Ethics of the Australian Medical Association / Australian Dental Association.
I agree to comply with the Continuing Professional Development requirement of my College.
I agree to hold adequate insurance for procedures I will carry out in this hospital and to promptly advise the CEO should:

(i) I be involved in a significant adverse event or adverse finding occurring at a Hospital or day procedure centre;

(ii) initiation of review, investigation or an adverse finding (whether formal or informal) be made against myself by AHPRA or the Medical Board of Australia (or other responsible board where applicable) or the Victorian Civil and Administrative Tribunal (VCAT);

(iii) my professional registration be revoked, suspended or amended;

(iv) professional indemnity insurance or membership of a medical defence organisation be made conditional or not be renewed; or

(v) my appointment at any other hospital or day procedure centre be adversely altered in any way including, without limitation, the imposition of any restriction or condition on my appointment or scope of practice.

_____ _____
Signature Date

CHECKLIST

Please ensure your application includes:

☐ Copy of your current AHPRA registration

☐ Copy of your current Professional Indemnity Insurance

☐ Name and contact details of 1 referee, attach written reference if available

☐ Identity check – 100 point documents (*certified copies)*

☐ National Police Check Certificate issued within the past twelve (12) months

☐ Working With Children Check

☐ Signed declaration (above)

Please ensure all above items are included in the completed application to ensure timely processing

7. AUTHORITY TO OBTAIN PRIVATE AND PERSONAL INFORMATION

I, _____ of _____

in the State of Victoria, hereby acknowledge, agree and consent to, The Bays Healthcare Group Inc.:

1. Contacting such persons and making such enquiries as are necessary to obtain personal and private information ("the information") about me so as to enable The Bays Healthcare Group Inc. to properly assess my application.
2. Exchanging such information with such third parties as is considered necessary for the purposes of assessing my application.
3. Using the information for the purposes of assessing my application.

In providing this Authority, I acknowledge that The Bays Healthcare Group Inc. will hold the information strictly on a confidential basis and will use the information solely for the purposes of assessing my application. I agree that this Authority may be presented to third parties as proof of my consent to them providing to The Bays Healthcare Group Inc. such documents and information as may be requested by it to assess my Application. I agree to sign such further documents and do what may be required to enable The Bays Healthcare Group Inc. to obtain the information.

Signature: _____ Date: _____

Please return completed documentation to:

Executive Assistant
The Bays Hospital
PO Box 483
Vale Street
Mornington Vic 3931

Phone: 03 5976 5275
Fax: 03 5975 2216
Email: executive@thebays.com.au