THE BAYS

APPLICATION FOR VISITING PRIVILEGES
MEDICAL PRACTITIONER

SURNAME: _____ **DATE:** _____

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

DATE OF BIRTH: _____

CONTACT DETAILS:

PROFESSIONAL ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ FAX: _____

MOBILE: _____

EMAIL:_____

PRIVATE ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ MOBILE:_____

EMAIL:_____

Please attach an abridged version of your Curriculum Vitae

OFFICE USE ONLY:

☐ Approval CEO Name: _____ Signed: _____Date: _____

☐ Approval MAC Chair Name: _____ Signed: _____Date: _____

☐ Approval Craft Group Rep Name: _____ Signed: _____Date: _____

Date tabled at MAC _____

Date tabled at Board _____

☐ ePas ☐ Database ☐ MAC ☐ Email to applicant ☐ Email to staff

THE BAYS

APPLICATION FOR VISITING PRIVILEGES
MEDICAL PRACTITIONER

1. SCOPE OF PRACTICE

You must tick the Specialty and then all relevant sub-special ties you are seeking

☐ **Allied Health**
Please specify are below:
_____
_____

☐ **Anaesthesia**
- ☐ Adults
- ☐ Neonatal (< 1 year old)
- ☐ Obstetric
- ☐ Paediatric (> 1 year old)
- ☐ Cardiac – Adult Only
- ☐ Trans-oesophageal Echocardiography (TOE) – Adult Only
- ☐ Chronic Pain Management

☐ **Cardiac Perfusion**

☐ **Cardiology**
- ☐ Cardiologist
- ☐ Procedural Cardiologist
- ☐ Interventional Cardiologist
- ☐ Electro physiologist

☐ **Emergency Medicine**
- ☐ Adult
- ☐ Paediatric

☐ Gastroenterology
please provide evidence of your certification (CCRTGE)
- ☐ Diagnostic Upper Gastrointestinal Endoscopy
- ☐ Therapeutic Upper Gastrointestinal Endoscopy
- ☐ Sclerotherpy
- ☐ Oesophageal Banding & Placement of Oesophageal Prostheses
- ☐ Oesophageal Dilatation
- ☐ Flexible Sigmoidoscopy
- ☐ Diagnostic Colonoscopy
- ☐ Therapeutic Colonoscopy endoscopic
- ☐ Retrograde Cholangiopancreatography (ERCP) & associated Therapeutic Interventions
- ☐ Biliary Stenting
- ☐ Percutaneous Endoscopic Gastrostomy (PEG)

☐ **Gynaecology - General**
- ☐ Advanced Endoscopic Surgery
- ☐ Gynaecology General
- ☐ Laparoscopic Surgery
- ☐ Prolapse Surgery
- ☐ Ultrasound
- ☐ Assisted Reproductive Services
- ☐ Gynaecological Oncology
- ☐ Uro-Gynaecology

☐ **Intensive Care**
- ☐ Adult
- ☐ Paediatric

MEDICINE

☐ General Medicine
- ☐ Adults Only
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Geriatrics
- ☐ Hepatology
- ☐ Immunology
- ☐ Infectious Diseases
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Oncology
  - ☐ Adults Only
  - ☐ Medical Oncology
- ☐ Radiation Oncology (provide copy of Radiation licence)
- ☐ Palliative Care
- ☐ Haematology
- ☐ Rehabilitation
- ☐ Renal Medicine
  - ☐ Nephrology - General
  - ☐ Nephrology - Interventional
  - ☐ Renal Dialysis
- ☐ Respiratory Medicine
  - ☐ Bronchoscopy - Diagnostic
  - ☐ Bronchoscopy - Therapeutic
  - ☐ Sleep Medicine
- ☐ Rheumatology

☐ **Pathology**
- ☐ Anatomical
- ☐ Biochemistry
- ☐ Chemical Pathology
- ☐ General Pathology
- ☐ Genetics
- ☐ Immunology Haematology
- ☐ Infectious Diseases
- ☐ Laboratory Haematology
- ☐ Microbiology

☐ **Psychiatry**
- ☐ General Adult
- ☐ Consultation - Liaison
- ☐ Addiction Psychology
- ☐ PTSD (EMDR)
- ☐ ECT
- ☐ Eating Disorder
- ☐ Psychotherapy

RADIOLOGY

☐ **Diagnostic Imaging**
- ☐ Adult
- ☐ Paediatric
- ☐ Bone Mineral Densitometry (BMD)
- ☐ Computerised Tomography (CT Scan)
- ☐ Fluoroscopy
- ☐ Magnetic Resonance Imaging (MR)
- ☐ Mammography
- ☐ Nuclear Medicine
- ☐ Radiation Oncology
- ☐ Standard Diagnostic Radiography
- ☐ Stress Testing
- ☐ Ultrasound

☐ **Interventional Radiology**
- ☐ Adult
- ☐ Paediatric
- ☐ Cardiac Catheterisation
  - ☐ Diagnostic (perform at least 100 Procedures per year)
  - ☐ Interventional (perform at least 75 Procedures per year)
- ☐ Interventional Radiology Service
  - ☐ Tier A
  - ☐ Tier B
- ☐ Vascular Catheterisation
  - ☐ Diagnostic
  - ☐ Interventional

☐ **Nuclear Medicine**
- ☐ Adult
- ☐ Paediatric
- ☐ Anatomical Pathology
- ☐ Conventional Gamma Cameras
- ☐ Position Emission Tomography (PET)

SURGERY

☐ Cardiothoracic Surgery
- ☐ Adult Only
- ☐ Valvular Procedures
- ☐ Coronary Artery Bypass
  - ☐ Off Pump Procedures
  - ☐ Minimally Invasive Surgery
- ☐ Arrhythmia Surgery
- ☐ Thoracic Aorta Procedures
- ☐ Thoracic Lung Procedures
- ☐ Insertion of Pacemaker

APPLICATION FOR VISITING PRIVILEGES MEDICAL PRACTITIONER

☐ **Dental**
- ☐ Adult
- ☐ Paediatric

☐ **ENT Surgery**
- ☐ Adult
- ☐ Paediatric
- ☐ Adenoidectomy
- ☐ Bronchial Procedures
- ☐ Ear Procedures
- ☐ Facial Nerve
- ☐ Laryngeal Procedures
- ☐ Nasal Procedures
- ☐ Otolaryngology – Head & Neck
- ☐ Pharyngeal Procedures
- ☐ Tonsillectomy
- ☐ Tracheal Procedures

☐ **General Surgery**
- ☐ Adult
- ☐ Colorectal Surgery
- ☐ Endocrine Surgery
  - ☐ Adrenalectomy
  - ☐ Thyroidectomy
- ☐ Endoscopic Surgery
- ☐ Gastrointestinal Surgery
- ☐ Laparoscopic Surgery
  - ☐ Diagnostic
  - ☐ Interventional
- ☐ Upper GI Surgery

☐ **General Surgery – sub speciality**
- ☐ Paediatric
- ☐ Breast Surgery
- ☐ Hepatobiliary & Pancreatic Surgery
- ☐ Oesophagectomy
- ☐ Bariatric – Adults & Adolescents (16-18yo) only
  - ☐ Lap Banding
  - ☐ Modified Roux-en Y
  - ☐ Sleeve Gastrostomy

☐ **Neurosurgery**
- ☐ Adult Only
- ☐ Nerve Procedures
- ☐ Spinal Procedures

☐ **Obstetrics**
- ☐ Maternal Fetal Medicine
- ☐ Obstetrics
- ☐ Ultrasound
- ☐ Uro-gynaecology

☐ **Ophthalmology**
- ☐ Adult
- ☐ Paediatric
- ☐ Cataract Surgery
- ☐ Corneal transplantation
- ☐ Eyelid Surgery
- ☐ Glaucoma Surgery
- ☐ Lacrimal Surgery
- ☐ Oculoplastic
- ☐ Orbital Surgery
- ☐ Ptergyium Surgery
- ☐ Refractive Surgery
- ☐ Squint Surgery
- ☐ Vitreoretinal Surgery

☐ **Oral & Maxillofacial Services**
- ☐ Adult
- ☐ Paediatric
- ☐ Facio Maxillary Surgery
- ☐ Mandibular Osteotomy

☐ **Orthopaedics - General**
- ☐ Adult
- ☐ Paediatric
- ☐ Arthroscopy
- ☐ Fracture Management
- ☐ Major Joint Replacement

☐ **Orthopaedics – sub speciality**
- ☐ Reconstructive Surgery
- ☐ Spinal Surgery

☐ **Paediatric Medicine**
- ☐ General Medicine
- ☐ Neonatology level 11 (34 weeks or later)

☐ **Paediatric Surgery**
(Excluding non therapeutic procedures)

☐ **Plastic & Reconstructive Surgery**
- ☐ Adult
- ☐ Paediatric
  - ☐ Bats Ears Only
  - ☐ Repair of Lacerations Only
  - ☐ Revision of Scars Only
- ☐ Abdominal Reductions
- ☐ Augmentation
- ☐ Breast Surgery
- ☐ Cosmetic Rhinoplasty
- ☐ Endoscopic Brown Surgery
- ☐ Facial Surgery
- ☐ Gender Reassignment
- ☐ Laser Ablation (Provide copy of radiation licence)
- ☐ Liposuction
- ☐ Neurovascular Flaps

☐ **Urology - General**
- ☐ Adult
- ☐ Paediatric (Excluding non therapeutic procedures))
- ☐ Endoscopic Urology
- ☐ Laparoscopic Urology
- ☐ Laser (Provide copy of radiation licence)
- ☐ Open Urological Procedures (ESWL Not available at this hospital)

☐ **Urology – Sub-speciality**
- ☐ Brachytherapy
- ☐ HiFU
- ☐ Lithotripsy

☐ **Vascular Surgery**

☐ Procedure:
- ☐ Anastomosis
- ☐ Arterial Patch
- ☐ Bypass
- ☐ Decompression
- ☐ Embolectomy
- ☐ Endarterectomy
- ☐ Ligation of Aneurysms
- ☐ Repair
- ☐ Replacement
- ☐ Thrombectomy
- ☐ Vascular Trauma of the following:
  - ☐ Adnominal
  - ☐ Aortic
  - ☐ Mesenteric
  - ☐ Open
- ☐ Axillary, Subclavian
- ☐ Carotid Procedure - Endoluminal
- ☐ Carotid Surgery - Open
- ☐ Endovascular Procedures
  - ☐ AAA Stent Grafts
  - ☐ Carotid Interventions
  - ☐ Diagnostic Procedures
  - ☐ Embolization Procedures
  - ☐ Peripheral Interventions
  - ☐ Renal Stenting
  - ☐ Femoral
  - ☐ Iliac
  - ☐ Jugular
  - ☐ Renel
  - ☐ Temporal
  - ☐ Thoracic

☐ **Other**

_____

_____

_____

_____

_____

_____

2. QUALIFICATIONS

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

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

3. 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

4. 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

5. HOSPITAL APPOINTMENTS

CURRENT PUBLIC HOSPITAL APPOINTMENTS:

_____

_____

_____

6. REFERENCES

REFERENCES

List two referees who may be contacted - at least one referee should be from the applicant's discipline.
To ensure impartiality, references will not be accepted from relatives/family of the applicant.

(1) REFEREE NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

EMAIL:_____

(2) REFEREE NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

EMAIL:_____

Please attach written references 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

7. 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.*

8. AFTER HOURS EMERGENCY CARE PROVISIONS

IMPORTANT

THE FOLLOWING SECTIONS MUST BE COMPLETED BY ANY PRACTITIONER WHO PLANS TO ADMIT AND/OR MANAGE THE CARE OF INPATIENTS

1. **Should the need arise for hospital staff to contact you AFTER HOURS, what provisions do you have for this?** For example, pager, home phone number or After Hours Roster with colleagues.

1st Preference: ☐ **Mobile Phone** ☐ **Pager** ☐ **Home Phone**

Number: _____

In the event that I am unable to be contacted for a clinical emergency, the person nominated below is an appropriately qualified, accredited* practitioner who has agreed to deputise for me:

**The practitioner must accredited at The Bays Hospital*

Name of nominated practitioner: _____

Telephone: (w)_____(m)_____(h) _____

2. **OBSTETRICS**

FIRST NOMINATED OBSTETRICIAN:_____

Address: _____

_____ Postcode: _____

Phone (professional): _____ Phone (home): _____

Mobile: _____ Pager: _____

SECOND NOMINATED OBSTETRICIAN: _____

Address: _____

_____ Postcode: _____

Phone (professional): _____ Phone (home): _____

Mobile: _____ Pager: _____

9. 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, reduced 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:

☐ An abridged version of your current Curriculum Vitae

☐ Copy of your current AHPRA registration

☐ Copy of your current Professional Indemnity Insurance

☐ Names and contact details of 2 referees, attach written references if available

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

☐ Details of your After Hours Emergency care provision

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

☐ Working With Children Check

☐ Evidence of your certification (CCRTGE) (*if performing colonoscopies*)

☐ Evidence of your COVID-19 Vaccination (immunisation history record or your COVID-19 digital certificate)

☐ Signed declaration (above)

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

10. 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