Application for Accreditation

of Visiting Medical Practitioners

LAKEVIEW

PRIVATE HOSPITAL

Dear Doctor

Thank you for your interest in working at Lakeview Private Hospital. Please find enclosed herewith the following documents:

- Application for Accreditation
- Various authorities to release information (Please complete the one that is relevant to your current indemnity company – disregard the ones that are not applicable)
- Working with children Check Information Pamphlet.

Please complete the relevant documents and return as soon as possible so that temporary approval may be granted to you.

Kindly ensure that all "Required Documents" as listed in the Application are submitted with your return mail.

Regards

Jennie McKenna

Administration

Email: accreditation@lakeviewprivate.com.au

Surname Please Print	
First Names Please Print	
Business/rooms Address of Applicant	
Telephone Fax Mobile:	B: _____ H: _____ F: _____ M: _____
Email Address:	
Home Address:	
Preferred mailing address:	☐Business ☐Residential
Lakeview Private Provider Number:	
D. O. B.	
Working With Children Check Number	WWC: or APP:
Undergraduate qualifications: Degrees/Diplomas:	
Year of Graduation: University:	
Post Graduate qualifications: Degrees Diplomas:	
Year of Graduation: University:	
Post Graduate qualifications: Degrees Diplomas:	
Year of Graduation: University	
Nominated Practitioner to contact in the event you are un-contactable **(N.B. must be accredited at Lakeview Private Hospital)**	

Current Hospital Appointments:	
	Training Hospitals: Overseas Post Graduate Experience: Recent Publications:
Medical Leadership positions:	
Details of clinical activity and outcomes undertaken in last 12 months. Details of completion of CME requirements from appropriate institution.	
Details of involvement in clinical audits, research, peer review activities and continuing medical programs	

Accreditation sought in the following categories:

☐ Specialist Practitioner
☐ Consultant Emeritus
☐ Dental Assist
☐ Registrar Assist
☐ GP Assist
☐ Nurse Surgical Assist
☐ CMO
☐ Rehabilitation Physician
☐ Surgical Assist
☐ Geriatric Physician
☐ Allied Health Professional

Registered Specialty/ Sub- Specialty:

Accreditation (Please tick):

☐ Permanent

☐ Temporary From ___ / ____ / ____ to ___/ ____/ ____

Clinical privileges are sought in the field(s) of: (Not applicable to surgical assistants)

☐ Anaesthesia
- ☐ Adult ☐ Paediatric ☐ Pain Medicine
- ☐ Epidural Anaesthesia

☐ Oral Surgery

☐ Oral and maxillofacial surgery

☐ ENT
- ☐ Adult ☐ Paediatric ☐ Head and neck

☐ Gastroenterology
- ☐ Colonoscopy (GESA Certification*) ☐ Gastroscopy (GESA Certification*) ☐ Endoscopic Ultrasound (GESA Certification*)

☐ General Surgery
- ☐ Endoscopy ☐ Laparoscopic Surgery ☐ Paediatric
- ☐ Bariatric

☐ Geriatric Medicine

☐ Gynaecology
- ☐ Reproductive Endocrinology and Fertility Services
- ☐ Laparoscopy ☐ Colposcopy

☐ Infectious Diseases

☐ Ophthalmology

☐ Orthopaedic
- ☐ EPA IA22 Radiology License*

☐ Plastic and Reconstructive

☐ Urology
- ☐ Cystoscopy

☐ Rehabilitation Physician

Other Privileges sought:

Professional Referees Names and Contact Details

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

_____

Preference for Operating Sessions:

_____

Registration

Please record your current registration number with the AHPRA and provide a photocopy

Number:_____

Paid to:_____

Are there any restrictions attached to this registration? ☐ No ☐Yes

If yes provide details: _____

_____

Medical Defence:

Please record the name of your Medical Defence/Professional Indemnity Insurer and provide a photocopy

Registration No.:_____

Paid to:_____

Please attach your usual Curriculum Vitae

Please attach evidence of COVID-19 Vaccination

Declarations:

Please circle *have/have not*, if have is circled further information may be required by the credentialing committee

I Select had disciplinary action against me or sanctions imposed by an organization or registration board.

I Select been involved in a criminal investigation and

I Select had a conviction against me.

I Select physical or mental condition or substance abuse problem that could affect my ability to exercise my requested scope of clinical practice.

I declare that these statements are true and correct. In applying for this position I agree to abide by the policies and procedures of Lakeview Private Hospital and any terms and conditions that may be applied to my appointment by the Medical Advisory Committee

I authorise a member of the Credentialing Committee to seek relevant information to support my application regarding my professional performance and fitness to practice my craft

I agree to participate in educational and quality assurance activities when requested.

Regular signature of applicant: _____

Print Name: _____ **Date:** _____

Required attachments:

- ☐Copy of Medical Registration
- ☐Copy of Medical Defence details
- ☐Copy of Qualifications/Certificates
- ☐Copy of current resume
- ☐Copy WWC check - *in compliance with Lakeview Private Hospital Policy*
- ☐* Copy of GESA Certification – *Recertification required every 3 years*
- ☐* Copy EPA IA22 Radiology License