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 have/ have not had disciplinary action against me or sanctions imposed by an organization or registration board.

I have/ have not been involved in a criminal investigation and

I have/ have not had a conviction against me.

I have/ have no 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
- ☐Evidence of COVID-19 vaccination
- ☐Copy WWC check - *in compliance with Lakeview Private Hospital Policy*
- ☐* Copy of GESA Certification – *Recertification required every 3 years*
- ☐* Copy EPA IA22 Radiology License

MDA National
Support Protect Promote

Third Party Disclosure Authority

This Third Party Disclosure Authority form allows you to provide authority to a Third Party/Parties or an Authorised Person nominated by you to access your Membership and Policy information. The Third Party/Parties will have access to your Certificate of Currency, which confirms your indemnity cover including any non-standard terms that have been issued (if applicable). Any Authorised Person you nominate will be able to act on your behalf in relation to your Membership and Policy, depending on the level of authority that you provide.

If you choose to do this you can be assured that we will take reasonable steps to protect your personal information from unauthorised access in accordance with the Privacy Act 1988 (Cth). You can view our Privacy Policy at mdanational.com.au or contact us on **1800 011 255**. We will also appropriately identify any Third Party/Parties or Authorised Person when they contact us.

Please return this form to us either by:
Email: peaceofmind@mdanational.com.au
Fax: 1300 011 244
Post: MDA National, Reply Paid 85186, SOUTHBANK VIC 3006

1. My personal details

Member number:	
First name:	Last name:
Preferred mailing address	
Email:	Telephone:

2. Authority type

Please select from the following options:

I authorise MDA National Insurance to provide a copy of my Certificate of Currency to:

☑ The following Hospital/Practice(s) (please provide full name and address):

a) Lakeview Private Hospital, 17-19 Solent Circuit, Norwest NSW 2153

b) _____

c) _____

☑ Any third party. This may include, but is not limited to hospitals, employers, employees or medical boards. It is important to be aware that by selecting this option you are authorising your Certificate of Currency to be provided to any third party.

I authorise MDA National Insurance to provide my nominated Authorised Person, or any person who provides the below password, with access to the following (please tick the appropriate box(es) below nominating your preference):

☐ Information relating to my Membership and Policy

☐ Make amendments to my Membership and Policy such as my contact details, field of practice and/or Gross Annual Billings

☐ Information relating to any claims, investigations and inquiries that relate to me

Please select one of the following options:

My nominated Authorised Person is:

First name:	Last name:
Date of birth:	

Or, any person who provides the following password: ☐☐☐☐☐☐☐☐ (Limit 8 characters)

If selecting the password option, the password must be provided prior to MDA National Insurance disclosing any of your information. It is your responsibility to maintain the confidentiality of your password and only provide it to any person/s you authorise to act on your behalf. MDA National Insurance will not be responsible for verifying that any person using your password has been properly authorised by you to do so.

*Your password can be changed at any time by contacting our Member Services team on **1800 011 255** and the authorisation will remain current until it is revoked by you.*

Please sign and date here

Signed:	Date: / /

Authority to Release Information

I, _____ ,
Avant Insured's Full Name

Avant Member ID _____
Member Code or Member Number

hereby authorise Avant Insurance Limited (ACN 003 707 471) to provide confirmation of my indemnity insurance to the medical facility/ies(named in full) listed as follows:

Lakeview Private Hospital

17-19 Solent Circuit, Norwest NSW 2153

The information provided may include the following details:

- name
- address
- Avant member ID
- policy number
- policy start and end dates
- policy limit
- category of practice
- State of practice

This authority will continue until otherwise revoked in writing by myself.

Signed:_____ Date: _____
Avant Insured's Signature

This completed form should be returned to Avant Insurance Limited:

- by fax to 1800 228 268
- by mail to PO Box 746, Queen Victoria Building NSW 1230

Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Level 28 HSBC Centre 580 George Street Sydney NSW 2000
PO Box 746 Queen Victoria Building Sydney NSW 1230
DX 11583 Sydney Downtown **Website** www.avant.org.au
Telephone 02 9260 9000 **Facsimile** 02 9261 2921
Freecall 1800 128268 **Freefax** 1800 228268

A subsidiary of Avant Mutual Group Limited ABN 58 123 154 898
Registered Office Level 28 HSBC Centre 580 George Street Sydney NSW 2000

Delegation of Authority

Important information

- MIPS takes your privacy seriously. Any personal information MIPS collects from you on this form or any other way is held securely and in accordance with the The *Privacy Act 1988* (Cwlth). This legislation restricts how an organisation collects, uses, discloses and stores personal information. MIPS is bound by this legislation, and is unable to provide any details regarding your membership to anyone other than yourself without your written authority.
- This form should be used by members who wish to allow a third party (ie a 'nominated representative') such as spouse, relative, practice manager or employer to obtain information regarding their MIPS membership or if nominated make amendments to their membership contact details.
- The nominated representative will not be able to make changes to membership details (eg membership category or practice state, cancel membership or access any non-membership information such as claims data).
- Requests are replied to by email to the nominated representative.
- Nominated businesses authorities (eg organisations/hospitals) will be held with the business not an individual.
- Individuals nominated by a business will be used as a contact person only.
- Contact number, email and relationship (eg spouse, relative, employer, and practice manager) must be provided for all delegations.
- Date of birth is not required for nominated businesses.

Please ensure that you read the important information section above. All sections are to be completed, please print clearly.

Step 1: Member details

Title

Surname

First names

Member number

Date of birth D D / M M / Y Y

Mobile | |

Alternate phone

Email (please print clearly)

Step 2: Nominated representative

Title

Surname

First names

Business name (if applicable)

LAKEVIEW PRIVATE HOSPITAL

Business address (if applicable)

Address 17-19 Solent Circuit

Suburb Norwest

Postcode 2153 State NSW

Country AUSTRALIA

Relationship (eg spouse)

Date of birth D D / M M / Y Y

Mobile | |

Alternate phone

Email (please print clearly)

Step 3: Member declaration

I authorise MIPS to provide personal information relating to my membership such as the category of my membership, my period of membership cover and any other details relevant to demonstrating that I am a member, to the nominated business or individual representative outlined above. I understand I may revoke this delegation at any time by advising MIPS. I understand it is my responsibility to advise MIPS if any existing delegation of authorities is to be removed.

I authorise my nominated representative to make amendments to my membership contact details (e.g. correspondence address): ☐ No ☐ Yes.

Signature

Sign here

Date D D / M M / Y Y

Completed application forms can be mailed or emailed. PO Box 25 Carlton South Vic 3053 | info@mips.com.au