LDS

Liverpool Day Surgery

105-119 Longstaff Ave, Chipping Norton (Moorebank), 2170
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E-MAIL: admin@liverpooldaysurgery.com.au
www.liverpooldaysurgery.com.au

APPLICATION FOR LISTING AS A CREDENTIALED MEDICAL OFFICER WITH DELINEATION OF CLINICAL PRIVILEGES

I, _____
(Full Christian names and surname in block letters)

wish to apply for listing as a Credentialed Medical Officer to Liverpool Day Surgery.

Residential Address and Telephone Number: _____

_____

Practice Address and Telephone Numbers: _____

_____

Address for correspondence/reports *(Please indicate)* Home ☐ Practice ☐

Mobile Number: _____

Email Address: _____

Date of Birth: _____

Provider Number: _____

Emergency Contact Number: _____

PROFESSIONAL DATA:

Initial Qualifications: Degree/Diploma Issuing Body Year

_____

_____

_____

_____

Additional Qualifications: _____

Hospitals where experience was obtained and training appointments:

_____

_____

_____

Type of current practice:

(a) General Practice YES / NO

Special Interests _____

(b) Registered Specialty _____

Specialist Registration in NSW YES / NO

PRESENT HOSPITAL APPOINTMENTS:

Public _____

_____

Other Hospitals to which you admit patients _____

_____

_____

Day Surgery Privileges sought: *(Please tick)*

- Anaesthesia
- Gastroscopy
- Colonoscopy
- EUS
- Gastric Balloons
- General surgery:- Please specify type_____
- Gynaecology:- Please specify type_____
- IVF
- Ophthalmology:- Please specify type_____

ANTICIPATED VOLUME AND FREQUENCY OF WORK

(Please detail anticipated requirements)

(a) Anticipated item Numbers to be used _____

_____

(b) Theatre Utilisation _____

Has there been any prior change to your defined scope of clinical practice, or denial, suspension, conditions attached to your practice, termination or withdrawal of the right to practice (other than for organisational need and/or capability reasons) in any other organisation? **NO** **YES** *(please comment)*

Has there been any prior disciplinary action or professional sanctions imposed by any registration board, Medicare, complaints body, criminal investigation or conviction, physical or mental condition or substance abuse problem that could affect a medical practitioner's ability to exercise the requested scope of clinical practice? **NO** **YES** *(please comment)*

For each specialty in which you are seeking privileges, please provide names, addresses email addresses and telephone numbers of two peer referees in Australia who can attest to your recent practice and who are not related to you nor financially linked with or financially dependent on you.

Name of Referee 1	**Name of Referee 2**
Address	**Address**
Contact Number	**Contact Number**
Email Address	**Email Address**

DECLARATION

I declare that I am the person named in this application and that to the best of my knowledge the statements herein contained are true in substance and fact.

I agree to abide by the provisions set down by the By-Laws (copy enclosed), the policies and procedure manuals of the hospital and conditions of appointment to Credentialed Officers.

I am willing to participate in the orientation and quality improvement programs at the hospital.

I am willing to participate in the Risk Management programs.

I consent for the committee to verify with relevant individuals, external organisations and nominated referees the validity of all claims made.

I consent for the CEO to access the Medical Registration Board website on an annual basis to confirm my “Authority to Practice”.

Signature _____ Date _____

Please return application form to the Administration of Liverpool Day Surgery.

Medical staff 65 years and over are reviewed annually by the Medical Advisory Committee.

With application, please enclose a copy of:

- Current Medical board registration
- Applicable Conjoint/GESA certification/recertification
- Police check
- Working with children certificate
- Medical Indemnity Cover
- Immunisation record including COVID vaccination
- Current CV

FOR OFFICE USE ONLY

Date of Medical Advisory Committee confirmation _____

Signature of MAC Chairperson (Sign & Print)_____

Privileges Granted _____

Date for Reapplication _____