

# APPLICATION FOR VISITING PRIVILEGES

## ALLIED HEALTH PROFESSIONALS



NEW APPLICATION

*(Please attach a copy of your Curriculum Vitae)*

RENEWAL APPLICATION

SURNAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

FIRST NAMES: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DISCIPLINE/SPECIALTY: \_\_\_\_\_

ADDRESS:

PROFESSIONAL: \_\_\_\_\_

\_\_\_\_\_  
POSTCODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL ADDRESS : \_\_\_\_\_

PRIVATE: \_\_\_\_\_

\_\_\_\_\_  
POSTCODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

GRADUATE			POST GRADUATE		
Qualification	Year Awarded	Regn Number	Qualification	Year Awarded	Regn Number

PROVIDER NUMBER \_\_\_\_\_

ARE YOU REGISTERED TO PRACTICE IN VICTORIA/ AUSTRALIA? \_\_\_\_\_

*(Please attach a copy of your current Certificate of Registration)*

ARE YOU CURRENTLY INSURED?

Yes  No

NAME OF INSURANCE ORGANISATION: \_\_\_\_\_

CERTIFICATE NUMBER: \_\_\_\_\_

LEVEL AND TYPE OF COVER: \_\_\_\_\_

*(Please attach a copy of your current certificate of membership which indicates your level of cover)*

**CURRENT PUBLIC HOSPITAL APPOINTMENTS**

\_\_\_\_\_  
\_\_\_\_\_

**REFERENCES** *(For new Applications only)*

List two (2) Referees who may be contacted. At least one (1) referee should be from the applicant's discipline.

**HOWEVER, the Referees should NOT be from the applicant's own practice.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

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

**DECLARATION**

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 ..... Association.

I

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PLEASE ENSURE PAGES 3 & 4 ARE COMPLETED**

OFFICE USE ONLY			
Date of MAC ratification:	Application successful:	Yes	No
Signed off by MAC Chairman:			

**AFTER HOURS  
EMERGENCY CARE PROVISIONS**

**IMPORTANT**  
SECTION ONE OF THIS PAGE MUST BE COMPLETED AND/OR  
SECTION 2 AND 3 IF APPLICABLE

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.**

\_\_\_\_\_

2. **Please provide contact details of a nominated, accredited allied health practitioner who, if you are unable to be contacted in an emergency, has agreed to attend the hospital in a timely manner appropriate to the circumstances of the emergency and who will deputise for you.**

Name: \_\_\_\_\_

Address:

Professional: \_\_\_\_\_

Private: \_\_\_\_\_

Phone: Professional \_\_\_\_\_ Private \_\_\_\_\_

Mobile \_\_\_\_\_ Pager \_\_\_\_\_

Mobile \_\_\_\_\_ Pager \_\_\_\_\_

To : The Bays Hospital

## AUTHORITY TO OBTAIN PRIVATE AND PERSONAL INFORMATION

I,.....of.....  
in the State of Victoria, hereby acknowledge, agree and consent to, The Bays Hospital :

1. Contacting such persons and making such inquiries as are necessary to obtain personal and private information (“the information”) about me so as to enable The Bays Hospital 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 Hospital 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 Hospital 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 Hospital to obtain the information.

Signature..... Date.....