APPLICATION FOR VISITING PRIVILEGES

MEDICAL PRACTITIONERS

❑ NEW APPLICATION
(Please attach a copy of your Curriculum Vitae)

❑ RENEWAL APPLICATION

SURNAME:______________________________TITLE: ____________________

FIRST NAMES:____

DATE OF BIRTH: ____

DISCIPLINE/SPECIALTY:____
(Please clearly define Specialty or if GP include any surgical areas ie Surgical Assistance)

DO YOU WISH TO APPLY FOR **OBSTETRIC** PRIVILEGES? ❑ Yes ❑ No

ADDRESS:

PROFESSIONAL: ____

______________________________POSTCODE: ____________________

PHONE:______________________________FAX:____________________

EMAIL ADDRESS : ____

PRIVATE:____

______________________________POSTCODE: ____________________

PHONE:______________________________MOBILE:____________________

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

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 Medical 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.

______________________________ ____________________
Signature Date

PROFESSIONAL REGISTRATION

ARE YOU REGISTERED TO PRACTICE IN AUSTRALIA?_______________________________________

CURRENT REGISTRATION NUMBER WITH THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY:____

(Registration details will be downloaded from the Australian Health Practitioner Regulation Agency)

PROFESSIONAL INDEMNITY INSURANCE

ARE YOU CURRENTLY INSURED? ❑ Yes ❑ No

NAME OF MEDICAL DEFENCE ORGANISATION:____
DENTAL

CERTIFICATE NUMBER:____

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

OR

Complete the relevant Authority to Release Information on Page 5.

HOSPITAL APPOINTMENTS & REFERENCES

CURRENT PUBLIC HOSPITAL APPOINTMENTS

____

____

REFERENCES *(For new Applications only)*
List two (2) Referees who may be contacted. At lease 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

The Bays Hospital

AFTER HOURS
EMERGENCY CARE PROVISIONS

IMPORTANT

THE FOLLOWING SECTIONS MUST BE COMPLETED BY ANY **DOCTOR** 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.**

   ____

2. **Please provide contact details of a nominated, accredited medical 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_________________________

3. **OBSTETRICS**

   FIRST NOMINATED OBSTETRICIAN: _______________________________

   Address:____

   ______________________________Postcode____________________

   Phone: Professional_____________________Private_____________________

   Mobile_________________________Pager_________________________

   SECOND NOMINATED OBSTETRICIAN:______________________________

   Address:____

   Phone :___________________________Postcode ____________________

   Phone: Professional_____________________Private_____________________

   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...

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

The Bays Hospital

AUTHORITY TO RELEASE INFORMATION
DELEGATION OF AUTHORITY
FOR THE PURPOSES OF PROFESSIONAL INDEMNITY INSURANCE ONLY

I,____

Insured's full name – print

Member ID____

Member code or Member Number

hereby authorise ____

Name of Insurer ie: Avant Insurance / Medical Indemnity Protection Society Ltd (MIPS)/ Guild Insurance

to provide confirmation of my indemnity insurance to:

Executive Assistant
The Bays Hospital Group Inc ABN 35 146 117 211
Tel: 03 5976 5275
262-268 Main Street
Mornington Vic 3931

I understand I may revoke this delegation at any time by advising my Insurer in writing.

The information provided may include the following details:

- Name
- Address
- Member ID
- Policy number
- Policy start and end dates
- Policy Limit
- Category of practice
- State of practice

This authority to release information is valid for 3 years

Signed:______________________________________ Date:________________________________

Insured's Signature