

# APPLICATION FOR VISITING PRIVILEGES ALLIED HEALTH

SURNAME: \_\_\_\_\_ DATE: \_\_\_\_\_

FIRST NAME(S): \_\_\_\_\_ TITLE: \_\_\_\_\_

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

**CONTACT DETAILS:**

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

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

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

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

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

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

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

TELEPHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

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

**OFFICE USE ONLY:**

Approval CEO Name: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Approval MAC Chair Name: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Date tabled at Credentialing Committee \_\_\_\_\_

ePas  Database  Credentialing Committee  Email to applicant  Email to staff

### 1. SCOPE OF PRACTICE

You must tick the Specialty and then all relevant sub-specialties you are seeking

**Allied Health**

Please specify are below:

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**Anaesthesia**

- Adults
- Neonatal (< 1 year old)
- Obstetric
- Paediatric (> 1 year old)
- Cardiac – Adult Only
- Trans-oesophageal Echocardiography (TOE) – Adult Only
- Chronic Pain Management

**Cardiac Perfusion**

**Cardiology**

- Cardiologist
- Procedural Cardiologist
- Interventional Cardiologist
- Electro physiologist

**Emergency Medicine**

- Adult
- Paediatric

Gastroenterology

**please provide evidence of your certification (CCRTGE)**

- Diagnostic Upper Gastrointestinal Endoscopy
- Therapeutic Upper Gastrointestinal Endoscopy
- Sclerotherapy
- Oesophageal Banding & Placement of Oesophageal Prostheses
- Oesophageal Dilatation
- Flexible Sigmoidoscopy
- Diagnostic Colonoscopy
- Therapeutic Colonoscopy endoscopic
- Retrograde Cholangiopancreatography (ERCP) & associated Therapeutic Interventions
- Biliary Stenting
- Percutaneous Endoscopic Gastrostomy (PEG)

**Gynaecology - General**

- Advanced Endoscopic Surgery
- Gynaecology General
- Laparoscopic Surgery
- Prolapse Surgery
- Ultrasound
- Assisted Reproductive Services
- Gynaecological Oncology
- Uro-Gynaecology

**Intensive Care**

- Adult
- Paediatric

**MEDICINE**

- General Medicine
  - Adults Only
  - Dermatology
  - Endocrinology
  - Geriatrics
  - Hepatology
  - Immunology
  - Infectious Diseases
  - Internal Medicine
  - Neurology
  - Oncology
    - Adults Only
    - Medical Oncology
  - Radiation Oncology (provide copy of Radiation licence)
  - Palliative Care
  - Haematology
  - Rehabilitation
  - Renal Medicine
    - Nephrology - General
    - Nephrology - Interventional
    - Renal Dialysis
  - Respiratory Medicine
    - Bronchoscopy - Diagnostic
    - Bronchoscopy - Therapeutic
    - Sleep Medicine
  - Rheumatology

**Pathology**

- Anatomical
- Biochemistry
- Chemical Pathology
- General Pathology
- Genetics
- Immunology Haematology
- Infectious Diseases
- Laboratory Haematology
- Microbiology

**Psychiatry**

- General Adult
- Consultation - Liaison
- Addiction Psychology
- PTSD (EMDR)
- ECT
- Eating Disorder
- Psychotherapy

**RADIOLOGY**

**Diagnostic Imaging**

- Adult
- Paediatric
- Bone Mineral Densitometry (BMD)
- Computerised Tomography (CT Scan)
- Fluoroscopy
- Magnetic Resonance Imaging (MR)
- Mammography
- Nuclear Medicine
- Radiation Oncology
- Standard Diagnostic Radiography
- Stress Testing
- Ultrasound

**Interventional Radiology**

- Adult
- Paediatric
- Cardiac Catheterisation
  - Diagnostic (perform at least 100 Procedures per year)
  - Interventional (perform at least 75 Procedures per year)
- Interventional Radiology Service
  - Tier A
  - Tier B
- Vascular Catheterisation
  - Diagnostic
  - Interventional

**Nuclear Medicine**

- Adult
- Paediatric
- Anatomical Pathology
- Conventional Gamma Cameras
- Position Emission Tomography (PET)

**SURGERY**

- Cardiothoracic Surgery
  - Adult Only
  - Valvular Procedures
  - Coronary Artery Bypass
    - Off-Pump Procedures
    - Minimally Invasive Surgery
  - Arrhythmia Surgery
  - Thoracic Aorta Procedures
  - Thoracic Lung Procedures
  - Insertion of Pacemaker

## ALLIED HEALTH

**Dental**

- Adult
- Paediatric

**ENT Surgery**

- Adult
- Paediatric
- Adenoidectomy
- Bronchial Procedures
- Ear Procedures
- Facial Nerve
- Laryngeal Procedures
- Nasal Procedures
- Otolaryngology – Head & Neck
- Pharyngeal Procedures
- Tonsillectomy
- Tracheal Procedures

**General Surgery**

- Adult
- Colorectal Surgery
- Endocrine Surgery
  - Adrenalectomy
  - Thyroidectomy
- Endoscopic Surgery
- Gastrointestinal Surgery
- Laparoscopic Surgery
  - Diagnostic
  - Interventional
- Upper GI Surgery

**General Surgery – sub-speciality**

- Paediatric
- Breast Surgery
- Hepatobiliary & Pancreatic Surgery
- Oesophagectomy
- Bariatric – Adults & Adolescents (16-18yo) only
  - Lap Banding
  - Modified Roux-en Y
  - Sleeve Gastrotomy

**Neurosurgery**

- Adult Only
- Nerve Procedures
- Spinal Procedures

**Obstetrics**

- Maternal Fetal Medicine
- Obstetrics
- Ultrasound
- Uro-gynaecology

**Ophthalmology**

- Adult
- Paediatric
- Cataract Surgery
- Corneal transplantation
- Eyelid Surgery
- Glaucoma Surgery
- Lacrimal Surgery
- Oculoplastic
- Orbital Surgery
- Pterygium Surgery
- Refractive Surgery
- Squint Surgery
- Vitreoretinal Surgery

**Oral & Maxillofacial Services**

- Adult
- Paediatric
- Facio Maxillary Surgery
- Mandibular Osteotomy

**Orthopaedics - General**

- Adult
- Paediatric
- Arthroscopy
- Fracture Management
- Major Joint Replacement

**Orthopaedics – sub speciality**

- Reconstructive Surgery
- Spinal Endoscopy
- Spinal Surgery

**Paediatric Medicine**

- General Medicine
- Neonatology level 11 (34 weeks or later)

**Paediatric Surgery**

(Excluding non-therapeutic procedures)

**Plastic & Reconstructive Surgery**

- Adult
- Paediatric
  - Bats Ears Only
  - Repair of Lacerations Only
  - Revision of Scars Only
- Abdominal Reductions
- Augmentation
- Breast Surgery

- Cosmetic Rhinoplasty
- Endoscopic Brown Surgery
- Facial Surgery
- Gender Reassignment
- Laser Ablation (Provide copy of radiation licence)
- Liposuction
- Neurovascular Flaps

**Urology - General**

- Adult
- Paediatric (Excluding non-therapeutic procedures)
- Endoscopic Urology
- Laparoscopic Urology
- Laser (Provide a copy of radiation licence)
- Open Urological Procedures (ESWL Not available at this hospital)

**Urology – Sub-speciality**

- Brachytherapy
- HiFU
- Lithotripsy

**Vascular Surgery**

- Procedure:
  - Anastomosis
  - Arterial Patch
  - Bypass
  - Decompression
  - Embolectomy
  - Enderterectomy
  - Ligation of Aneurysms
  - Repair
  - Replacement
  - Thrombectomy
  - Vascular Trauma of the following:
    - Adnominal
    - Aortic
    - Mesenteric
    - Open
  - Axillary, Subclavian
  - Carotid Procedure - Endoluminal
  - Carotid Surgery - Open
  - Endovascular Procedures
    - AAA Stent Grafts
    - Carotid Interventions
    - Diagnostic Procedures
    - Embolization Procedures
    - Peripheral Interventions
    - Renal Stenting
    - Femoral
    - Iliac
    - Jugular
    - Renal
    - Temporal
    - Thoracic

**Other**

**Surgical Assistant**

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## 2. QUALIFICATIONS

GRADUATE		
Qualification	Year Awarded	Reg Number

POSTGRADUATE		
Qualification	Year Awarded	Reg Number

## 3. PROFESSIONAL REGISTRATION

ARE YOU REGISTERED TO PRACTICE IN AUSTRALIA?  Yes  No

CURRENT REGISTRATION NUMBER WITH THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY: \_\_\_\_\_

**Please provide a copy of your AHPRA registration**

## 4. PROFESSIONAL INDEMNITY INSURANCE

ARE YOU CURRENTLY INSURED?  Yes  No

NAME OF INSURANCE PROVIDER: \_\_\_\_\_

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

**Please attach a copy of your current certificate of insurance which indicates your level of cover**

## 5. HOSPITAL APPOINTMENTS

CURRENT PUBLIC HOSPITAL APPOINTMENTS:

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## 6. REFERENCES

### REFERENCES

List a referee who may be contacted: The referee should be from the applicant's discipline.

\*To ensure impartiality, references will not be accepted from relatives/family of the applicant, exceptions apply in this instance and an alternative referee is to be supplied

REFEREE NAME: \_\_\_\_\_

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

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

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

**Please attach a written reference if available**

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

## 7. MEDICAL REGISTRATION STATUS / IDENTITY / SECURITY CHECK

Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked?  Yes  No

Do you have conditions attached to that appointment for any reason?  Yes  No

Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol-related offence?  Yes  No

Do you currently have any restrictions on your practice imposed by AHPRA?  Yes  No

Are you the subject of any current or historical pending regulatory body review (including AHPRA and Medicare) or any criminal charges?  Yes  No

If you answered **Yes** to any of the above questions, please provide full details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Or, if you prefer, provide the information in a sealed envelope marked 'Confidential for medical director only' appended to this application, and indicate here that additional information is provided separately in this manner.**

**8. DECLARATION & CHECKLIST**

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 / Australian Dental 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 and to promptly advise the CEO should:

- (i) I be involved in a significant adverse event or adverse finding occurring at a Hospital or day procedure centre;
- (ii) initiation of review, investigation or an adverse finding (whether formal or informal) be made against myself by AHPRA or the Medical Board of Australia (or other responsible board where applicable) or the Victorian Civil and Administrative Tribunal (VCAT);
- (iii) my professional registration be revoked, suspended or amended;
- (iv) professional indemnity insurance or membership of a medical defence organisation be made conditional or not be renewed; or
- (v) my appointment at any other hospital or day procedure centre be adversely altered in any way including, without limitation, the imposition of any restriction or condition on my appointment or scope of practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CHECKLIST**

**Please ensure your application includes:**

- Copy of your current AHPRA registration
- Copy of your current Professional Indemnity Insurance
- Names and contact details of 1 referee, attach written references if available
- Identity check – 100-point documents
- National Police Check Certificate issued within the past twelve (12) months
- Working With Children Check
- Evidence of your COVID-19 Vaccination (immunisation history record or your COVID-19 digital certificate)
- Evidence of your current Flu Vaccination (immunisation history record or your digital certificate)
- Signed declaration (above)

**Please ensure all the above items are included in the completed application to ensure timely processing**

## 9. AUTHORITY TO OBTAIN PRIVATE AND PERSONAL INFORMATION

I, \_\_\_\_\_ of \_\_\_\_\_  
in the State of Victoria, hereby acknowledge, agree and consent to, The Bays Healthcare Group Inc.:

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Please return the completed documentation to:

Executive Assistant  
The Bays Hospital  
PO Box 483  
Vale Street  
Mornington Vic 3931

Phone: 03 5976 5275  
Fax: 03 5975 2216  
Email: executive@thebays.com.au