ST KILDA
DAY HOSPITAL

26A Dickens Street
Elwood VIC 3184
Tel: 03 9537 3638
Fax: 03 9593 9632
ACCREDITED

Dentist application/VMO Application/ Re-application for Credentialing

ST KILDA DAY HOSPITAL

Please note: If you need to correct any error in your application, please initial the correction.

Surname ……..……..

First name…….Middle name……..

This is a:

New application	☐
Renewal/reapplication	☐
Altered scope of practice	☐

PATIENT WEIGHT LIMIT - Due to Health & Safety considerations, patients whose weight is greater than 110 Kg cannot be treated at this hospital

1. Application for scope of clinical practice

I wish to apply for accreditation and clinical privileges in:

Anaesthesia: ☐ General ☐ Pain Management

Surgery: ☐ General ☐ Plastic Surgery ☐ Cosmetic Surgery ☐ Dental

Please fill in section 4 to define specific privileges

Please attach to this form:

All applications/reapplications

- Copy of current professional indemnity insurance certificate (if applicable).
- Copies of relevant visa documents (if applicable).

New appointments only

- Current curriculum vitae.
- Copies of all specialist or other qualifications
- Proof of identification - 100 point check - Verification of signatory - 100 point check as required by Austrac http://www.austrac.gov.au/ - see attached.

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2. Applicant contact details

Surname	
Given name/s	
Previous name (if it appears on certificates).	
Date of birth	
Place of birth	
Residency status (Australian citizen/ permanent/temporary resident if changed since last application).	
Professional address	Postcode
Postal address (if different to professional address above).	
Phone (BH)	
Phone (AH)	
Fax	
Mobile/pager	
Contact e-mail address	
Emergency contact	Name Contact details

Do you have a Provider number/s for this location? If NO – please note that you will be required to obtain one – the organisation can assist. If YES, is it subject to any restrictions? If restrictions apply, please provide full details.	Yes ☒ No ☒ Site Provider number/s: Yes ☒ No ☒
Do you have a Prescriber number?	Yes ☒ No ☒ Prescriber number:

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3. All qualifications, including your basic dental degree

New appointments only- please provid copies of qualifications obtained.
Reappointments, or those seeking to extend current scope of practice –please provide new qualifications obtained since last appointment.

Qualifications	University/organisation	Year obtained
Primary medical degree		
Others		
Reappointment only	Are you requesting a change to your existing scope of practice? ▪ If Yes, please go to section 4 ▪ If No, please go to Section 5	Yes ☐ No ☐

4. Application for scope of clinical practice
I wish to apply to define my scope of clinical practice to undertake the following - tick all relevant boxes.

☐ Group 1 Oral health practitioner	☐ General dentistry. ☐ Dental therapy. ☐ Dental hygiene. ☐ Dental prosthetics.
☐ Group 2 Specialist dentistry	☐ Endodontics. ☐ Prosthodontics.* ☐ Periodontics.* ☐ Orthodontics. ☐ Oral medicine. ☐ Paediatric dentistry. ☐ Special needs dentistry. ☐ Dento-maxillofacial radiography. ☐ Oral & maxillofacial surgery.* *☐ including surgical/prosthetic placement of implants.

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☐ Cosmetic Surgery/ Plastic Surgery	**Please list:**
☐ Anaesthetist	

5. Clinical appointments

- New applications, or
- Application for a change in your scope of practice - please specify information relevant to change only.

If relevant, please provide details on all current and previous clinical appointments held within the last five years (including names of organisations and dates of appointment), or other places of practice (for example, general practice).

Organisation	Name and type of appointment	Term of appointment
		to
		to
		to
		to
		to
		to
		to
		to

6. Registration matters

What is your Registration Number?	_____
Is this registration specific?	Yes ☒ No ☒
Is this registration provisional?	Yes ☒ No ☒
If you have a specific or provisional registration, and/or you are to be supervised, please	

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provide details (including name and location of supervisor and frequency of supervision).	
Do you currently have any conditions or restrictions placed on your registration or your clinical practice (either in Victoria or any other state or country)?	Yes ☒ No ☒
In the past, have you ever had any conditions or restrictions placed on your registration (either in Victoria or elsewhere)?	Yes ☒ No ☒
Have you ever been the subject of disciplinary decision/ruling in the course of your work as an oral health practitioner?	Yes ☐ No ☒
Have you ever been the subject of prior disciplinary decision/ruling or professional sanctions imposed by any registration board, whether in Victoria or elsewhere?	Yes ☒ No ☒
Have you ever been denied a defined scope of clinical practice?	Yes ☐ No ☒
Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?	Yes ☐ No ☒
Have you ever been convicted or found guilty of any criminal offence, including a drug or alcohol related offence?	Yes ☐ No ☒
Are you the subject of pending criminal charges?	Yes ☒ No ☒
If YES to any of the above, please provide full details or, if you prefer, provide the information in a sealed envelope marked 'confidential for director of medical services or equivalent only' appended to this application, and indicate here that additional information is provided separately in this manner. Also, please provide a letter from the registration board.	
Are you registered as a dental practitioner in any other state or territory of Australia, or in another country? If so, please specify.	Yes ☒ No ☒

7. Indemnity information

Current professional indemnity cover (if applicable)* *Essential for rights to private practice. *Please attach a copy of current policy renewal certificate.*	Policy no: Expiry date:
Is your proposed scope of clinical practice reflected in, or covered by, your current indemnity insurance?	Yes ☒ No ☒

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Have there ever been or are there currently pending any claims, settlements or judgments against you?	Yes ☒ No ☒
Has your current or any previous insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	Yes ☒ No ☒
If the answer to any of the above is YES, please provide a detailed explanation and specify the name of the relevant dental insurer on a separate attachment.	

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10. Continuing professional development

(For example, participation in peer review, performance development review.)

Do you regularly participate in formal quality and peer review activities in any clinical setting?	Yes ☐ No ☐

Provide details of these quality/peer review activities.

11. Health status

Do you have a disability/health issue that: • May have an impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application? • May require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?, or • May be relevant to determining your scope of practice?	Yes ☒ No ☒

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12. Referees (new appointments only)

Please provide details of at least two referees, preferably within the specialty being applied for, who have been in a position to judge your qualifications and experience during the previous three years and who have no conflict of interest in providing a reference.

Referee 1

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
Phone (mobile)	
Fax	
E-mail address	

Referee 2

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
Phone (mobile)	
Fax	
E-mail address	

Referee 3

Name	
Position held currently	
Professional address	Postcode
Phone (BH)	
Phone (mobile)	
Fax	
E-mail address	

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13. Agreement/undertakings

I understand that in assessing my application, St Kilda Day Hospital will make additional enquiries as to my suitability for the position.

New applications only

I understand that the health service may conduct a criminal history check in relation to my current and previous place/s of residence.	Yes ☐ No ☐

New appointments and expanding scope of practice only

I authorise the health service to seek information as to my past experience, performance and current fitness to practise from my referees.	Yes ☐ No ☐
I agree to familiarise myself with relevant hospital by-laws, policies and procedures, and to abide by them.	Yes ☐ No ☐

All applications

I accept that the health service will obtain information relevant to my application from Australian Health Practitioner Regulation Agency and any other board regulating health practitioners, whether in Victoria or elsewhere.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my application from my current and any previous insurer.	Yes ☐ No ☐
I authorise the health service to obtain information relevant to my supervision requirements (where applicable).	Yes ☐ No ☐
I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation.	Yes ☐ No ☐
I agree to abide by the organisations' and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment.	Yes ☐ No ☐
I agree to notify the director of medical services or their delegate of any event/situation that may have an impact on my ability to exercise my scope of clinical practice, whether it be due to registration matters, or otherwise. This includes matters about which I consider that the director of medical services or their delegate would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions, reductions in registration or insurance).	Yes ☐ No ☐
I agree to comply with relevant ongoing educational and certification programs and to furnish details to the health service on an annual basis as requested by the director of medical services or their delegate.	Yes ☐ No ☐
I agree to participate in the health service's clinical supervision and performance appraisal process.	Yes ☐ No ☐
I agree to promptly notify the director of medical services or their delegate of any adverse clinical incident I am involved in, or of which I become aware.	Yes ☐ No ☐
I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.	Yes ☐ No ☐

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Should any question as to my credentialling or clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that credentialling or my scope of clinical practice is appropriate.	Yes ☐ No ☐

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14. Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant:_____Date:_____

Please note: if for any reason you are unable to sign the declaration above, please explain the circumstances.

Please note: The information collected on this form will be used by the St Kilda Day Hospital Credentialling and Scope of Clinical Practice Committee(s) to assist in the determination of your application. Information provided on this form will not be used or disclosed for any other purpose.

St Kilda Day Hospital operates in accordance with federal and state privacy legislation, including adherence to the National Privacy Principles. Copies of St Kilda Day Hospital Privacy and Confidentiality Policies are available upon request.

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Health service use only

Applicant name .....

Item	Checked/comments
1. Proof of identification.	❑
2. Contact details provided.	❑
3. Provider number.	❑
4. Prescriber number.	❑
5. Qualifications.	❑
6. Training and experience (if required).**	❑
7. Clinical appointments (if required).**	❑
8. Medical registration.	❑
9. Medical indemnity cover currency.	❑
10. Health status.	❑
11.Referees (if required).**	❑
12. Declaration signed.	❑

Other comments:

.....

.....

.....

.....

Application details checked by (name) .....

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

Letter to applicant advising outcome of application Yes ❑ Copy attached ❑

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100 points - Verification details

Type of check	Available points	Notes
Passport (current or expired by less than two years). Not cancelled . Citizenship certificate (Australian only). Birth certificate (original or extract). Birth card issued by the Victorian Registry of Births, Deaths and Marriages.	70	Must contain name and a photo. **Select one only.**
Written reference. Written reference from an acceptable referee from a financial institution.	40	**Select one only.** Referee to have known the signatory for at least 12 months. Both signatory and referee must sign the reference.
Drivers licence Renewed, interim, provisional, truck or learners. Other acceptable government-issued licences include boat, gun or pilot.	40	Must contain name, expiry date, a photo or signature.
Public Service Employee Identification Card.	40	
Pension or Government Health Card (reference number required).	40	
Identification card issued by a tertiary education institute.	40	
Letter from a current employer (current or must have been employed by the employer within the last two years)..	35	Must be on letterhead or company seal. Both employer and employee's signature must be on the letter as well as the name and address of the employee.
Medicare card. Overseas or International Drivers Licence Proof of Age Card.	25	
Financial institution credit card, cash card or passbook.	25	Only one current card/passbook can be accepted from each financial institution. You may supply details from several different institutions, but cannot solely rely on this form of identification.
Rating authorities Rate notice (current). Provide the Deposited Plan (DP) number.	35	
Public utility (water rate notice, electricity, gas or telephone account - no mobile accounts) - current - take notice with you.	25	

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Type of check	Available points	Notes
Statement from landlord, managing agent or owner of customer premises.	25	Take letter, rental contract or rent receipt with you.

Once your application is complete, please email your application with the subject line *Attention: Credentialing Officer* along with your accompanying documents to:

Olga Randall
Director of Nursing
ST KILDA DAY HOSPITAL
Email: don@stkilda-hospital.com.au