APPLICATION FOR ACCREDITATION

Application for accreditation as a medical practitioner including surgical assistants or dentist
Please submit completed application form to the CEO/DON of Cambridge Day Surgery

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For Reappointment:

If this is an application for reappointment and there are no changes to the information required in this application, you will only be required to tick the box, sign page 5 of this application and attach a copy of current Medical Defence Organisation certificate.

☐ This is an application for my reappointment and there are no changes to the information required in Application for accreditation since I last applied.

Surname of Applicant:	

First Names in full:	

Date of Birth (optional):	

Accreditation Category: (Please refer to page 3 for the list of category)	

Please tick ☐ preferred mailing address:

☐ Residential Address with postcode

Home Telephone:	Home Facsimile:

☐ Professional Address with postcode: (primary consulting room):

Rooms Telephone:	Rooms Facsimile:

Mobile Number:	Provider Number:

Email Address:

Undergraduate qualifications, university and year of graduation:

Postgraduate qualifications, degrees, diplomas: (attach CV if insufficient space)

Year obtained:	Special comments on post graduate experience:
Qualification:	
Authorising Body:	

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Hospital Appointments Within Last five Years:

Dates	Hospital	Appointment

Nature of current practice, place of work and special professional interests:

Accreditation sought in the following category(s):

☐ Specialist Practitioner ☐ Surgical Assistant (no admitting rights)

Registered specialty/sub-specialties:

For Surgical Assistant applicants only:
Name of accredited practitioner of Cambridge Day Surgery who will provide a reference for you:

Name	Contact Number	Hospital

Name	Contact Number	Hospital

Accreditation (please tick):

☐ Permanent ☐ Temporary

from <insert date>	to <insert date>

Clinical privilege are sought in the field(s) of: (not applicable to surgical assistants)

- ☐ **ANAESTHESIA**
  - ☐ Adult
  - ☐ Cardiac
  - ☐ Paediatrics
- ☐ **ENT SURGERY**
  - ☐ Adult
  - ☐ Paediatric
  - ☐ Head and Neck
- ☐ **GENERAL SURGERY**
  - ☐ Paediatric
- ☐ **GYNAECOLOGY**
  - ☐ Gynaecology General
  - ☐ Adult
- ☐ **ORAL AND MAXILLOFACIAL SURGERY**
- ☐ **ORTHOPAEDICS**
  - ☐ Adult
  - ☐ Paediatric
- ☐ **PAEDIATRIC SURGERY**
- ☐ **PODIATRY SURGERY**
- ☐ **PLASTIC AND RECONSTRUCTIVE SURGERY**
  - ☐ Hand Surgery
  - ☐ Facio Maxillary Surgery
  - ☐ Plastic, Reconstructive and Aesthetic Surgery
  - ☐ Head and Neck
- ☐ **RADIOLOGY**
- ☐ **UROLOGY**
  - ☐ Adult
  - ☐ Paediatric
- ☐ **VASCULAR SURGERY**

For each specialty in which you are seeking privileges, please provide names, addresses and telephone numbers of two peer references in Australia who can attest to your practice and who are not related to you nor financially linked with or financially dependent on you. (Not applicable to surgical assistants)

Specialty:		
Name of Referee 1:	Name of Referee 2:	
Contact details:	Contact details:	

Specialty:		
Name of Referee 1:	Name of Referee 2:	
Contact details:	Contact details:	

Please record your current registration number with the Australian Health Practitioner Regulatory Agency

Number:

Are there any conditions attached to this registration? Yes ☐ No ☐

If yes, provide details of conditions:

Please state the name of your Medical Defence Organisation or your Professional Indemnity Insurance Provider and provide photocopy:

Name:

Membership Number:

Category of membership (insert specialty) eg full surgeon:

Does your membership fully cover the types of privileges you have applied for: ☐ Yes ☐ No

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Appointment at other hospitals or day procedure centres:

Current/past:

Current/past:

Current/past:

Membership of colleges and/or other relevant Associations:

1.

2.

3.

4.

Have your clinical privileges and/or appointment at any hospital or day procedure centre ever been reduced, suspended or revoked or have you had conditions attached to that appointment for any reason? ☐ Yes ☐ No

If yes, give dates and particulars:

Please nominate a medical practitioner accredited at Cambridge Day Surgery in your specialty available for contact by Cambridge Day Surgery in case of an emergency if you are unavailable:

Name:

Specialty:

Contact Number(s):

Specialist Directory (not applicable for surgical assistants)

I authorize Cambridge Day Surgery to include my details in their Specialist Directory ☐ Yes ☐ No

Authority:

I hereby apply for accreditation at Cambridge Day Surgery with clinical privileges I have specified.

In making this application I acknowledge and agree:

- I have received a copy of the Cambridge Day Surgery By-Laws ☐
- I will abide by the By-Laws ☐
- Cambridge Day Surgery executives, its officers and the medical advisory committee may seek information about my past experience, clinical performance and current fitness. ☐

Signature: ____________________________________ Date: ____

Note: Evidence of Medical Defence Organisation must accompany this application.