BARWON HEALTH
APPLICATION FOR GENERAL & DENTAL PRACTITIONER CREDENTIALING APPOINTMENT
INITIAL APPOINTMENT FORM

Please complete and return to: **Dr Rodney Fawcett, Director Medical Education and Training**,
Barwon Health, Kitchener House, PO Box 281, Geelong Vic. 3220
Telephone: (03) 421 53243 Fax: (03) 421 53488
Email: rodney@barwonhealth.org.au

SECTION A: ALL APPLICANTS TO COMPLETE

PERSONAL DETAILS:

Australian Medical/Dental Board Number: _____ **Male** ☐ **Female** ☐

Title _____ **Surname** _____ **Given Names** _____

Preferred Name _____ **Prescriber Number** _____

Phone Number _____ **Email** _____

Practice Details 1 *(Please note: This will be your mailing address)*

Practice Name _____
Address _____
Suburb _____ Postcode _____ State/Territory _____
Country _____ Phone _____ Fax _____
Provider no _____

Practice Details 2 (if applicable)

Practice Name _____
Address _____
Suburb _____ Postcode _____ State/Territory _____
Country _____ Phone _____ Fax _____
Provider no _____

QUALIFICATIONS: to be attached with application form

1. MBBS/BDSc or equivalent (attach certified copy)	☐
2. Current unrestricted AHPRA Medical/Dental Registration (attach copy) Please note: This may be verified by Barwon Health	☐
3. Current Medical/Dental indemnity membership. Medical indemnity/insurance membership details (attach copy – must have expiry date listed)	☐
4. Detailed typewritten Curriculum Vitae outlining your professional background and current professional activities (attach copy)	☐
5. Evidence of General/Dental Practitioner Qualification (attach copy)	☐
6. Current Basic Life Support certification: **For GPs -** RACGP/ACCRM or equivalent (attach copy) **For Dental** – Evidence of BLS in your CPD (attach copy)	☐

PROFESSIONAL REFEREES: please include the names and addresses of three (3) professional referees

1)	**Contact**	**Phone number**
2)	**Contact**	**Phone number**
3)	**Contact**	**Phone number**

PRIVILEGES/SPECIALITIES REQUESTED:

PRIVILEGES/SPECIALITIES These privileges do not include admitting rights to University Hospital Geelong		**BARWON HEALTH SITE**
Aged Care (Residential Care)	☐	
Surgical Procedural/Assisting	☐	
Hospital Rotations	☐	
Clinical Assistant	☐	
Emergency Department	☐	
Shared Care - Psychiatry	☐	
Shared Care - Oncology	☐	
Shared Care - Antenatal	☐	**Complete additional Section B**
Up-skilling	☐	
Dental	☐	
Other – please specify:		

SECTION B: SHARED CARE - ANTENATAL

INITIAL APPOINTMENT

☐ 1. Attainment of Diploma RANZCOG or equivalent Date attained: _____

and/or ☐ 2. CSCT in Women's Health Date attained: _____

and/or ☐ 3. Attend 2 - 6 sessions in Pregnancy Care Clinic
(sessions required to be determined by supervising obstetrician)

and/or ☐ 4. Relevant postgraduate qualifications and experience - please detail

_____

_____

_____

_____

Complete Section C on the next page

SECTION C: AGREEMENT

I agree to the following undertakings (please tick and sign):

• If appointed, I agree to read and abide by the Bylaws, Rules and Policies of Barwon Health and the Medical Staff group, including those relating to peer review activities, and guidelines and protocols in respect of mutual patients.	☐
• I acknowledge that: o State legislation requires all senior Medical Practitioners hold professional indemnity insurance. o If I require further privileges to those requested in this application, I should apply in writing to the Credentialing Committee, care of Medical and Education and Training, PO Box 281, Geelong Vic 3220.	☐
• I will ensure the Medical Education and Training department at Barwon Health has up to date preferred contact information (telephone, facsimile, postal address).	☐
• I authorise the hospital to: o Exchange details of my shared care affiliation including contact details. YES ☐ NO ☐ o Provide patients and their families with my practice details. YES ☐ NO ☐	
Name (please print)	
Signature **Date**	

Office use only

Privileges granted	1	2	3
Appointment period:		Re-appointment due:	
Additional documentation required Y / N	Specify:		
Pregnancy Care clinic (PCC) attendance required? Yes ☐ No ☐			
Number of clinic (PCC) attendances recommended: 2 3 4 5 6			
Clinic PCC) attendance dates: ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___			
Application approved: Yes ☐ No ☐ Date: ___/___/___	Obstetric Medical Director: _____ Signature:		
Clinical attachment requested	Date completed		
Letter of appointment & relevant information sent	Date sent		
Signed Contract	Date received		
Data base entry date: ___/___/___			