

Please complete and return to: **Medical Education and Training**,
 Barwon Health, Kitchener House, PO Box 281, Geelong Vic. 3220
 Telephone: (03) 421 53274 Email: mirjana.stosic@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/BDS or equivalent (attach certified copy)	<input type="checkbox"/>
2. Current unrestricted AHPRA Medical/Dental Registration (attach copy) Please note: This may be verified by Barwon Health	<input type="checkbox"/>
3. Current Medical/Dental indemnity membership. Medical indemnity/insurance membership details (attach copy – must have expiry date listed)	<input type="checkbox"/>
4. Detailed typewritten Curriculum Vitae outlining your professional background and current professional activities (attach copy)	<input type="checkbox"/>
5. Evidence of General/Dental Practitioner Qualification (attach copy)	<input type="checkbox"/>
6. Current Basic Life Support certification: For GPs - RACGP/ACCRM or equivalent (attach copy)	<input type="checkbox"/>

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

1) Contact	Phone number
<input type="text"/>	<input type="text"/>
2) Contact	Phone number
<input type="text"/>	<input type="text"/>
3) Contact	Phone number
<input type="text"/>	<input type="text"/>

PRIVILEGES/SPECIALITIES REQUESTED:

<u>PRIVILEGES/SPECIALITIES</u>		BARWON HEALTH SITE
These privileges do not include admitting rights to University Hospital Geelong		
Aged Care (Residential Care)	<input type="checkbox"/>	
Shared Care - Antenatal	<input type="checkbox"/>	Complete additional Section B
Dental	<input type="checkbox"/>	
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):

<ul style="list-style-type: none"> • 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. 	<input type="checkbox"/>
<ul style="list-style-type: none"> • I acknowledge that: <ul style="list-style-type: none"> ○ State legislation requires all senior Medical Practitioners hold professional indemnity insurance. 	<input type="checkbox"/>

<ul style="list-style-type: none"> ○ 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. 	
<ul style="list-style-type: none"> • I will ensure the Medical Education and Training department at Barwon Health has up to date contact information (telephone, facsimile, postal address). 	<input type="checkbox"/>
<ul style="list-style-type: none"> • I authorise the hospital to: <ul style="list-style-type: none"> ○ Exchange details of my shared care affiliation including contact details. YES <input type="checkbox"/> NO <input type="checkbox"/> ○ Provide patients and their families with my practice details. YES <input type="checkbox"/> NO <input type="checkbox"/> 	
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 <input type="checkbox"/> No <input type="checkbox"/>			
Number of clinic (PCC) attendances recommended: 2 3 4 5 6			
Clinic PCC) attendance dates: __/__/__ __/__/__ __/__/__ __/__/__ __/__/__ __/__/__			
Application approved: Yes <input type="checkbox"/> No <input type="checkbox"/> 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: __/__/__			