

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
<input type="text"/>	<input type="text"/>	<input type="text"/>
Preferred Name	Prescriber Number	
<input type="text"/>	<input type="text"/>	
Phone Number	Email	
<input type="text"/>	<input type="text"/>	

Practice Details 1

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. Current Medical/Dental indemnity membership. Medical/Dental indemnity/insurance membership details (attach 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 Basic Life Support certification: For GPs - RACGP/ACCRM or equivalent (attach copy)	<input type="checkbox"/>

PRIVILEGES/SPECIALITIES REQUESTED:

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

SECTION B: SHARED CARE - ANTENATAL

RE-APPOINTMENT: – please detail Continuing Medical Education activities within the triennium prior to reaccreditation

- 1. Attend at least 2 Western Victoria Primary Health Network Pregnancy Care Lectures
- and/or 2. CME related to pregnancy care and perinatal care (attach copy of certificate)
- and/or 3. Attend 2 sessions in Pregnancy Care Clinic within the triennium prior to reaccreditation
- and/or 4. 10 RACGP Group 2 CPD points from activities directly related to pregnancy care, pre-pregnancy care and postnatal period CPD points (attach copy of certificate)

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. ○ 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. 	<input type="checkbox"/>
<ul style="list-style-type: none"> • I will ensure the Medical Education and Training Unit 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: ___/___/___			