New Appointment / Re-appointment/ Change of Scope of Practice for Nurses and Midwives

Application for Midwife credentialing appointment for Shared Maternity Care for Antenatal and Extended Postnatal Care

Annual appointment form

Shared Maternity Care means that a woman's pregnancy care is shared between the Geelong Hospital and Shared Maternity Care Affiliates who are accredited to provide Shared Maternity Care at The Geelong Hospital.

Shared Maternity Care is a model of care in which a woman is cared for by both hospital staff and a community based Shared Maternity Care Affiliates (General Practitioner or Midwife) throughout her pregnancy. The baby's birth and immediate postnatal care are managed by the hospital.

Credentialed Midwives will provide the woman's care prior to her admission(s) and after discharge from hospital postnatal care, but are not involved in the intrapartum or immediate postnatal care in the hospital.

The Geelong Hospital aims to provide a high quality community-based, holistic, safe and culturally appropriate Shared Maternity Care for women by providing Shared Maternity Care Affiliates with information to:

- delineate roles, responsibilities and expectations of different providers
- clarify pathways of referral, care and support
- assist providers in the provision of evidence based care and initiatives to support quality maternity care
- provide useful and relevant information for both providers and women

Surname ……..

First name…… Middle name……..

This is an application for:

New appointment	☐
Renewal of appointment	☐
Extension/Variation to scope of practice	☐

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

1. Application for extension to scope of practice

I wish to apply to be credentialed to practice as:

……

……

New or innovative procedures and/or techniques will be notified to the Clinical Innovations Committee for approval.

Please attach to this form:

All appointments/reappointments

- Copy of current Australian Health Practitioner Regulation Agency registration (refer question 6)
- Attach evidence detailing CPD activities
- Current curriculum vitae
- Copies of relevant visa documents (if applicable)

New appointments only

- Current curriculum vitae including details of CPD activities.
- Certified copies of all specialty or other qualifications (other than primary nursing degree, if these are not listed on the Australian Health Practitioner Regulation Agency website. http://www.ahpra.gov.au/en/Registration/Registers-of-Practitioners.aspx
- Proof of identification - 100 point test - Verification of signatory - 100 point check as required by Austrac http://www.austrac.gov.au/
- Working with children check, if applicable.

2. Applicant contact details

Surname	
Given name/s	
Previous name/s	
Date of birth	
Place of birth	
Residency status (If you are a not permanent resident please advise current visa type)	Australian citizen ☐ Permanent resident ☐ Temporary resident ☐
Professional address	Postcode
Postal address (if different to professional address above.)	
Phone (BH)	
Phone (AH)	
Fax	
Mobile/pager	
Contact e-mail address	

3. All qualifications including your primary nursing degree

- New appointments - please list all your qualifications.
- Reappointments (or if seeking to extend current scope of practice) – please list any new qualifications obtained since last appointment. Please provide certified copies of new qualifications obtained.

Qualifications	University/organisation	Year obtained
Primary nursing degree		
Others		

Reappointment only	Are you requesting a change to your existing scope of practice?	Yes ☐ No ☐

4. Specialist area of practice

4a. Specialty information

Primary specialty		Qualifications to support this specialty:
Sub-specialty or area of special interest (if applicable)	(Please provide supporting information in 5b.)	
Other specialty **(if applicable)**		Qualifications to support this specialty:
Are you applying to reduce your current scope of practice?		Yes ☐ No ☐
If Yes, please outline reasons for the proposed reduction of scope of practice.		

Scope of clinical practice sought including, where relevant, type of procedures you wish to undertake; (please use additional pages if required).

4b. Other training and clinical experience

If changing/extending your scope of practice, please provide details of relevant clinical experience and post-qualification training.
Include the title of course/s undertaken, the organisation offering the course and the qualification obtained.

5. Clinical appointments

Please provide details on all current and previous clinical appointments held within the last five years (including names of organisations and dates of appointment)

Organisation	Name and type of appointment	When did you work in that role?
		to
		to
		to
		to
		to
		to
		to
		to
		to

6. Nursing and Midwifery Board registration and other matters

Please refer to http://www.ahpra.gov.au

What is your Australian Health Practitioner Regulation Agency Registration number?	_____
Do you have an endorsement?	Yes ☐ No ☐
Please Specify	
Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a nurse/midwife?	Yes ☐ No ☐
Have you ever been the subject of prior disciplinary decision/s or ruling/s imposed by any registration board whether in Victoria or elsewhere?	Yes ☐ No ☐
Do you currently have any conditions or restrictions placed on your registration or your clinical practice (either in Victoria or any other state, territory 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 denied a scope of clinical practice that you requested?	Yes ☐ No ☐
Have you ever chosen to reduce your scope of 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 Executive Director of Nursing & Midwifery only' appended to this application, and indicate here that additional information is provided separately in this manner.	
Are you registered as a nurse / midwife in another country?	Yes ☐ No ☐ If yes, please specify.
Have you ever been registered as a nurse / midwife in another country?	Yes ☐ No ☐ If yes, please specify.
Do you have a current Working with Children Check * - see website Required for staff regularly providing services to children in paediatric wards. ***Please attach copy of current card***	Yes ☐ No ☐ N/A ☐ Card number: Expiry date:

*Working with Children information can be found at http://www.justice.vic.gov.au/workingwithchildren/

7. Medical indemnity insurance information to be confirmed

Current private medical indemnity insurance cover (if applicable). **Please attach a copy of current policy renewal certificate**	Name of insurer: _____ Policy number: _____ Expiry date: _____
Is your proposed scope of private clinical practice reflected in or covered by your current medical indemnity insurance?	Yes ☐ No ☐ N/A ☐
Have there ever been, or are there currently pending medical indemnity claims, settlements or judgments against you?	Yes ☐ No ☐
Has your current or any previous medical defence organisation/insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?	Yes ☐ No ☐

If the answer to either of the above two questions is YES, please provide a detailed explanation and specify the name of the relevant medical defence organisation/insurer.

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.

8. Academic appointments/teaching experience

Please provide details of current and previous university or hospital teaching appointments held within the last five years (including names of organisations and dates of appointment).

Organisation	Status/level	Term of appointment
		to
		to
		to
		to
		to
		to
		to

8a. Continuing Professional Development

*Please provide details of your involvement in **relevant** continuing professional development (CPD) over the last year. Include the name of the organisation/program in which you are enrolled, and maintenance of activity log book.*

Please provide copies of any log books, activity or certificate of satisfactory completion of CPD in the last five years.

Description of CPD activities undertaken **(please attach papers)**	Dates

8b. Quality activities
For example, participation in clinical review/audit/peer review activities.

Do you regularly participate in formal clinical reviews, audits and/or peer review activities in any clinical setting?	Yes ☐ No ☐

If Yes, please provide details of these activities, (please provide attachments if necessary).

9. Health service educational activities

Are you prepared to conduct educational activities at this health service?	Yes ☐ No ☐

10. Health status

Do you have a disability/health issue that: • may 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 • might be relevant to determining your scope of practice? • (In answering this question, please have regard to Australian Health Practitioner Regulation Agency guidelines available at http://www.ahpra.gov.au/Complaints-and-Outcomes/Conduct-Health-and-Performance/Health.aspx	Yes ☐ No ☐
If yes, please provide details of the disability/health issue and its likely, or possible, impact on your ability to carry out the scope of practice sought and details of any special equipment facilities or work practices required. This information can be provided on this form or, if you prefer, you can provide the information in a sealed envelope marked 'confidential for Executive Director of Nursing & Midwifery only' appended to this application and indicate here that additional information is provided separately in this manner. This information is sought to enable an assessment to be made as to whether you can safely perform the inherent/reasonable requirements of the work that you are seeking to perform at the hospital by submitting this application, or whether any reasonable adjustments might be required to ensure that you can work at the hospital in a way that ensures patient safety.	

11. Referees (new appointments or expanding scope of practice only)
Please provide details of at least two referees, who preferably work largely within the specialty being applied for, who have been in a position to judge your experience and performance 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	

12. Agreement/undertakings

I understand that, in assessing my application for appointment to Barwon Health, the health service will make additional enquiries as to my suitability for the position.

New applications only

I understand the health service will conduct a routine 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 from my referees as to my past experience, performance and current fitness to practise.	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 the 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 medical indemnity organisation/insurer.to be confirmed	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 ☐
If appointed, I agree to abide by the organisation's, 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 Executive Director of Nursing & Midwifery of any event/situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to nursing registration matters or otherwise. This includes matters about which I consider that the director/nursing leader 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 ☐
If appointed, I agree to comply with relevant ongoing educational/certification programs, (for example, college or relevant professional association/body) and to furnish details to the health service on an annual basis as requested by the Executive Director Nursing & Midwifery/nursing leader.	Yes ☐ No ☐
If appointed, I agree to participate in an annual professional development review.	Yes ☐ No ☐
If appointed, I agree to promptly notify the Executive Director of Nursing & Midwifery of any adverse clinical incident I am involved in, or become aware of.	Yes ☐ No ☐
If appointed, I agree to work within my specified scope of clinical practice and to make a further application should I seek to extend the scope of clinical	Yes ☐ No ☐

practice granted to me.	
If appointed, should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.	Yes ☐ No ☐
I agree to sign and abide by the *Privacy, Confidentiality & Security Agreement* form provided by Barwon Health.	

13. Declaration

As recommended under the Standard for Credentialing and Defining the Scope of Clinical Practice of the Australian Commission for Safety and Quality in Health Care, the health service requires that the following declaration is completed by applicants.

I hereby declare that I have not been subject to any prior change to the defined scope of clinical practice, or denial, suspension, termination or withdrawal of the right to practise (other than for organisational need and/or capability reasons) in any other organisations and that I have not been subject to any prior disciplinary action or professional sanctions imposed by any registration board.

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

Signature of applicant …… Date ……

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 Barwon Health Medical Appointments Committee to assist in the determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

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

100 points - Verification details (new appointments only)

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 along with the name and address of the employee.
Medicare card. Overseas or international drivers licence or Proof of Age card.	25	
Financial institution’s 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	
Statement from landlord, managing agent or owner of customer	25	Take letter, rental contract or rent

premises.		receipt with you.