LAKEVIEW
PRIVATE HOSPITAL

Welcome to Lakeview Private Hospital

Application for Accreditation

of Visiting Medical Practitioners

Patients **First**

lakeviewprivate.com.au

Dear Doctor,

Thank you for your interest in working at Lakeview Private Hospital.

Please find enclosed herewith the following documents:

- Application for Accreditation
- Various authorities to release information (Please complete the one that is relevant to your current indemnity company – disregard the ones that are not applicable)

Please complete the relevant documents and return as soon as possible so that temporary approval may be granted to you.

Kindly ensure that all "Required Documents" as listed in the Application are submitted with your email.

Thank you.

Regards,

Jennie McKenna
Administration
Email: accreditation@lakeviewprivate.com.au

Surname: Please Print	
First Name/s: Please Print	
Business/Practice Address:	
Work Phone: Fax: Mobile:	_____ _____ _____
Email Address:	
Home Address:	
Preferred mailing address:	☐ Business ☐ Residential
Lakeview Private Provider Number:	
D. O. B.:	
Working With Children Check Number:	**WWC:** or **APP:**
Undergraduate qualifications: Degrees/Diplomas:	
Year of Graduation: University:	
Post Graduate qualifications: Degrees Diplomas:	
Year of Graduation: University:	
Post Graduate qualifications: Degrees Diplomas:	
Year of Graduation: University	
Nominated Practitioner to contact in the event you are uncontactable **(N.B. must be accredited at Lakeview Private Hospital):**	

Current Hospital Appointments:	
Training Hospitals:	
Overseas Post Graduate Experience:	
Recent Publications:	
Medical Leadership positions:	
Details of clinical activity and outcomes undertaken in last 12 months. Details of completion of CME requirements from appropriate institution.	
Details of involvement in clinical audits, research, peer review activities and continuing medical programs.	

Accreditation sought in the following categories:

☐ Specialist Practitioner

☐ Consultant Emeritus

☐ Dental Assistant

☐ Registrar Assistant

☐ GP Assistant

☐ Nurse Surgical Assistant

☐ CMO

☐ Rehabilitation Physician

☐ Surgical Assistant

☐ Geriatric Physician

☐ Allied Health Professional

Registered Specialty/Sub-Specialty:

Accreditation: (Please tick)

☐ Permanent

☐ Temporary

From _____/ _____/ _____ to ___/ ____/ _____

Clinical privileges are sought in the field/s of: (Not applicable to surgical assistants)

☐Anaesthesia
☐Adult ☐ Paediatric ☐Pain Medicine
☐Epidural Anaesthesia

☐Oral Surgery

☐Oral and maxillofacial surgery

☐ENT
☐Adult ☐ Paediatric ☐ Head and neck

☐Gastroenterology
☐Colonoscopy (GESA Certification*) ☐ Gastroscopy (GESA Certification*) ☐ Endoscopic Ultrasound (GESA Certification*)
☐General Surgery
☐Endoscopy ☐ Laparoscopic Surgery ☐ Paediatric
☐Bariatric

☐Geriatric Medicine

☐Gynaecology
☐Reproductive Endocrinology and Fertility Services
☐Laparoscopy ☐ Colposcopy

☐Infectious Diseases

☐Ophthalmology

☐Orthopaedic

☐EPA IA22 Radiology License*

☐Plastic and Reconstructive

☐Urology

☐Cystoscopy

☐Rehabilitation Physician

Other Privileges sought:

Professional Referee/s: (Names and Contact Details)

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Preference for Operating Sessions:

Registration:

Please record your current registration number with AHPRA and provide a photocopy of your registration.

Number: _____

Paid to: _____

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

If yes, provide details: _____

Medical Defence:

Please record the name of your Medical Defence/Professional Indemnity Insurer and provide a photocopy of your membership.

Registration No.: _____

Paid to: _____

Declarations:

Please circle *have/have not*, if have is circled further information may be required by the credentialing committee.

I have / have not had disciplinary action against me or sanctions imposed by an organisation or registration board.

I have / have not been involved in a criminal investigation.

I have / have not had a conviction against me.

I have / have not *a* physical or mental condition or substance abuse problem that could affect my ability to exercise my requested scope of clinical practice.

I declare that these statements are true and correct. In applying for this position, I agree to abide by the policies and procedures of Lakeview Private Hospital and any terms and conditions that may be applied to my appointment by the Medical Advisory Committee.

I authorise a member of the Credentialing Committee to seek relevant information to support my application regarding my professional performance and fitness to practice my craft.

I agree to participate in educational and quality assurance activities when requested.

Regular signature of applicant: _____

Print Name: _____ **Date:** _____

Required attachments:

☐ Copy of Medical Registration

☐ Copy of Medical Defence details

☐ Copy of Qualifications/Certificates

☐ Copy of current resume

☐ Mandatory Training/CPD certificates – as per policy LPH-GEN001

☐ LPH137 Immunisation Declaration – Category A with accompanying evidence

☐ Copy of WWC check - *in compliance with Lakeview Private Hospital Policy*

☐ *Copy of GESA Certification – *Recertification required every 3 years*

☐ *Copy of EPA IA22 Radiology License

Patients First
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ABN 57 154 883 815