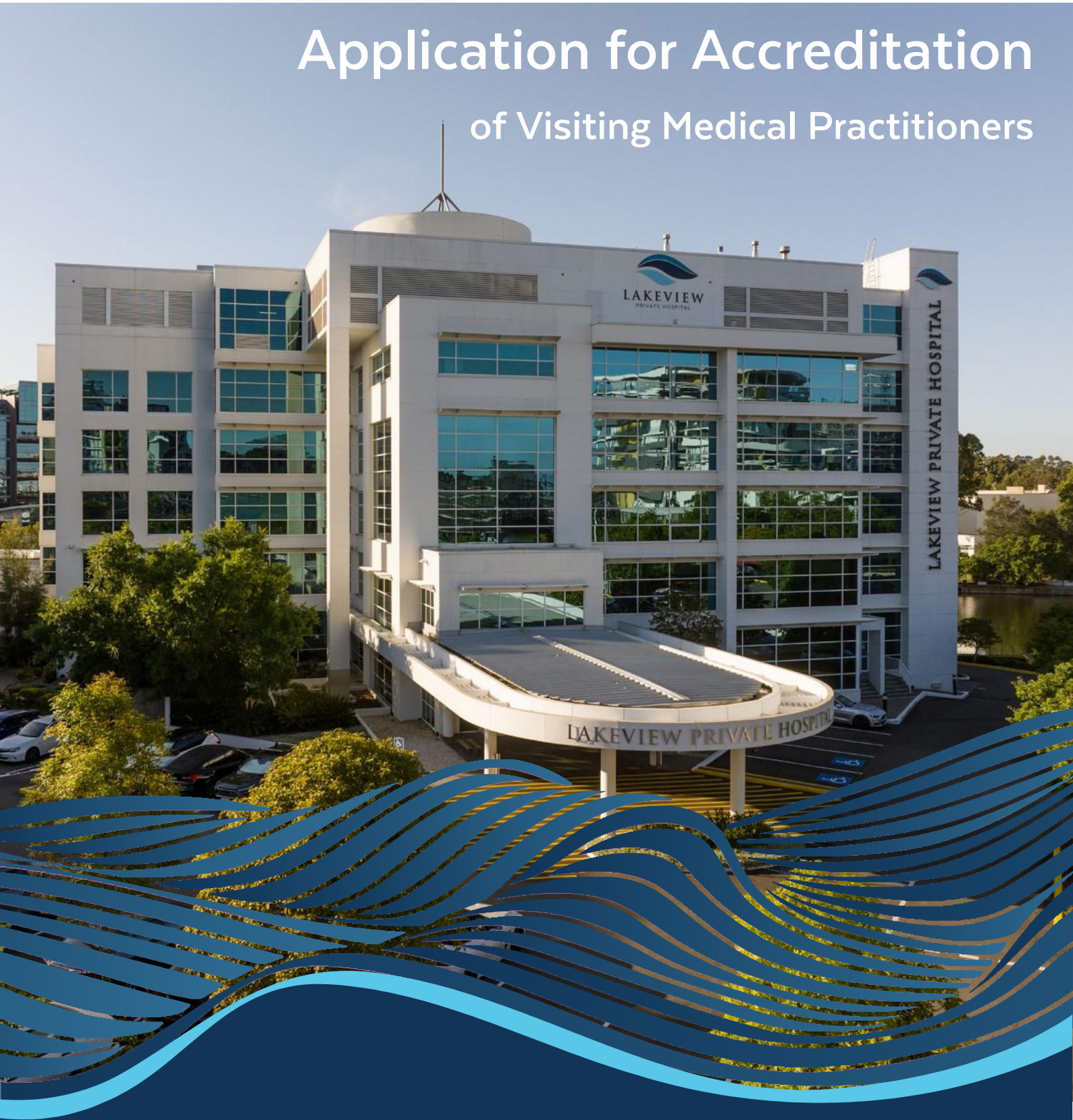
LAKEVIEW
PRIVATE HOSPITAL

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
- LPH 137 Immunisation Declaration Form
- Medical By-Laws

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.

Kind regards,

Susan Edwin
Administration
Email: accreditation@lakeviewprivate.com.au

Surname: Please Print	
First Name/s: Please Print	
D. O. B.	
Business/Practice Address:	
Work Phone: Mobile:	B:_____ M:_____
Email Address:	
Lakeview Private Provider Number:	
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):**	

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815

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 category:

☐ 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 ____/_____/_____

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815

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:

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815

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: _____

Working With Children Clearance:
Please record your current registration number with the WWC and **provide a photocopy**

Number: _____ **Expiry:** _____

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815

Required attachments:

☐Copy of Medical Registration
☐Copy of Medical Defence details
☐Copy of Qualifications/Certificates
☐Copy of current resume
☐Copy WWC check - *in compliance with Lakeview Private Hospital Policy*
☐LPH137 Immunisation Declaration - Category A with accompanying evidence
☐*Copy of GESA Certification - *Recertification required every 3 years*
☐Mandatory Training/CPD certificates - as per policy LPH-GEN001

CMO	***VMO (Surgeons, Anaesthetists and surgical assistants)***
Advanced Life Support	*ALS or BLS*
Blood Safe – Patient Blood Management Essentials https://learn.bloodsafelearning.org.au/course/details/pbm	*Hand Hygiene* https://hha.org.au/32-online-learning/login
Hand Hygiene https://hha.org.au/32-online-learning/login	*Basics of Infection Prevention and Control* https://hha.org.au/32-online-learning/login
Basics of Infection Prevention and Control https://hha.org.au/32-online-learning/login	*Fire training* https://www.flexiquiz.com/SC/N/lph-emergency
Fire – https://www.flexiquiz.com/SC/N/lph-emergency	*WHS – Introduction to Health and Safety in the Workplace*
WHS – Introduction to Health and Safety in the Workplace	

We are happy to accept certificates from other facilities and registered training organisations, provided they have been completed within the last four years.

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815

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:** _____

Patients First
17-19 Solent Circuit, Norwest, NSW 2153
02 8624 5000 02 8711 0577 info@lakeviewprivate.com.au lakeviewprivate.com.au
ABN 57 154 883 815