



## Application for Accreditation and Clinical Privileges

### PRIVILEGES SOUGHT

GENERAL PRACTICE   
MEDICAL SPECIALIST

SPECIALIST PSYCHIATRIST   
SPECIALIST ANAESTHETIST

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The Marian Centre  
187 Cambridge street  
Wembley, 6014  
PH: 9380 4999  
FX: 9388 3179

### TITLE

PROFESSOR   
MRS.   
OTHER :

DR.   
MS.

MR.   
MISS

**SURNAME**

**GIVEN NAMES**

### PREFERRED CONTACT ARRANGEMENTS

EMAIL

MOBILE

PHONE

PRACTICE

**DATE OF BIRTH:**

**NEXT OF KIN:**

**MOBILE PHONE:**

**N.O.K PHONE:**

### MEDICAL BOARD REGISTRATION

NUMBER:

### THE MARIAN CENTRE PROVIDER NUMBER

NUMBER:

### PRESCRIBER NUMBER

NUMBER:

### PROVIDER NUMBER

NUMBER:



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**PRIMARY PRACTICE**

ADDRESS/STATE/POSTCODE:

TELEPHONE BH:

**RESIDENTIAL DETAILS**

ADDRESS:

EMAIL ADDRESS:

TELEPHONE:

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**SECOND ON-CALL**

NAME:

CONTACT DETAILS:

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**SCOPE OF PRACTICE**

SPECIALTY/VOCATION:

POST- SPECIALY RECOGNITION:

AREAS OF SPECIAL INTEREST:

**CURRENT MEMBERSHIP OF PROFESSIONAL ASSOCIATIONS**

AMA

RANZ

OTHER:



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**PROFESSIONAL QUALIFICATIONS AND EXPERIENCE**

Please provide your Curriculum Vitae

**OR** complete the following:

DEGREE NAME:
NAME OF AWARDING BODY:
YEAR GRADUATED:
PRIMARY DEGREE:
POSTGRADUATE DEGREE(S):
POSTGRADUATE DIPLOMA/FELLOWSHIP:
OTHER DEGREES/DIPLOMA'S:
AWARDS & DECORATIONS:

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**PRESENT HOSPITAL APPOINTMENTS**

PLEASE PRINT PRIVATE AND PUBLIC HOSPITALS
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**ECT TRAINING AND EXPERIENCE**

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**RESEARCH INTERESTS**

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### PRACTICE HISTORY

Is investigation or enquiry into your professional practice currently being made by a medical registration board in any State or Territory of Australia or in any other country?

NO

YES

If yes, please provide full details:

Have you been subject to proceedings, disciplinary action or similar action by HIC, medical board, regulatory authority, or similar body?

NO

YES

if yes, please provide full details;

Has your scope of clinical practice ever been denied, suspended, terminated or the right to practice withdrawn in any organization?

NO

YES

if yes, please provide full details;

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### HEALTH/MRSA

As per the Policy of the Medical Board of Western Australia, it is a requirement that all staff members who have worked in a non-WA hospital in the preceding 12 months show evidence that they have been screened for multi-resistant Staphylococcus aureus. Further information can be obtained from a hospital's infection control coordinator.

Have you been a patient or worked in a hospital outside Western Australia within the past 12 months?

NO

YES

if yes, an MRSA screening must be performed through an outpatients pathology.

Have you had close contact with a known MRSA positive person in the past 12 months?

NO

YES

if yes, an MRSA screening must be performed through an outpatients pathology.

As far as you are aware, are you a current, or have you previously been an MRSA carrier?

NO

YES

If yes, please contact the infection control officer.



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**REFEREES**

Please give the names, addresses and telephone numbers of 3 referees from whom the hospital will seek details of your experience and skills. It is advisable that your referees have worked closely with you for a reasonable period of time in the past five years, and at least 2 are from your discipline.

**1.** NAME:

ADDRESS:

CONTACT DETAILS:

**2.** NAME:

ADDRESS:

CONTACT DETAILS:

**3.** NAME:

ADDRESS:

CONTACT DETAILS

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**DECLARATION**

I declare the answers I have given are true and correct to the best of my knowledge and belief.

I agree to participate in clinical and committee activities in the Marian Centre and support the activities directed at continuous improvement of clinical care.

I confirm that I have received and read a copy of the Marian Centre By-Laws and I agree to be bound by them.

I give consent for the Marian Centre to seek confirmation of professional indemnity insurance coverage from my professional indemnity insurance provider, when applicable.

Signature: \_\_\_\_\_

Date of Application: \_\_\_\_\_



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**CHECKLIST**

- **Please attach a recent colour passport size photograph of yourself**

It is a requirement of practice within the Marian Centre that you are registered to practice and carry indemnity cover relevant to your practice. Please provide copies of:

- **Your primary degree.**
- **Details of specialist recognition, where relevant**
- **Receipt of payment of your current registration**
- **Receipt of payment of your current Indemnity Cover**
- **Evidence Continuing Personal Development** (eg: Annual summary Medical Board)
- **Photocopy of Working with Children Check**
- **Curriculum Vitae**

Please note that in the event of your application being successful that the Marian centre will seek evidence of current registration and indemnity cover each year. Failure to provide this will result in lost accreditation and clinical privileges.

*Thank you for your interest.*

*Please ensure that you have completed all sections of the application form and attached documentation as required.*