Griffith UNIVERSITY

Griffith Health Clinics

Clinical Privileging Application Form

❖ Please note that incomplete applications will not be considered ❖

1. Personal Details

Title (eg: Dr, Ms, Mr, A/Prof, Prof)		
Surname		
Given Name(s)		
Any former names (including maiden name)		
Medicare Prescriber No.		
Medicare Provider No. (Griffith University site only)		
Radiation Licence No. (if applicable)		**Expiry:**

Residential Address			
	Post Code		
Telephone		**Pager No.**	
Facsimile		**Mobile No.**	
Date of Birth			

Practice Address (if applicable)			
	Post Code		
Telephone		**Facsimile**	
Email			

Postal Address:	
	Post Code

Griffith UNIVERSITY

Griffith Health Clinics

Application for Clinical Privileges in Griffith Health Clinics

2. Clinical Practice Sought

I hereby apply to Griffith University Health Group for Appointment as a Privileged (credentialed) Practitioner within the Griffith Health Clinics and seek appointment for the category and privileges indicated. To support my application I submit the following information.

When complete, please print and sign the form and submit (with relevant documentation) to Ciara Dolan: Griffith Health Clinics; G40_8.49; Gold Coast campus; Griffith University; QLD; 4222
Fax: 07 5678 0798; Email: c.dolan@griffith.edu.au

CLINICAL PRACTICE SOUGHT IN THE FOLLOWING CATEGORY(S) (Please tick all relevant categories)

Category (position in the Clinic)		
☐	Treatment Rights	
	☐	Intra-mural Professional Practice (Griffith staff member working within workload)
	☐	Private Practice (Griffith staff member working outside of workload)
	☐	External Practitioner (non-Griffith employee)
☐	Clinical Teacher/Supervision	
☐	Clinical Research – non-Clinical Trials Unit	
☐	Clinical Research – Clinical Trials Unit	

CLINICAL PRACTICE SOUGHT IN THE FOLLOWING DISCIPLINE AND SPECIALITY AREAS (Please tick all relevant categories)

Dentistry	
☐	General Dentistry
☐	Specialisation (please indicate below)

Medicine	
☐	General Practitioner
☐	Specialisation (please indicate below)

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Other Oral Health	
☐	Oral Health Therapist
☐	Dental Prosthetist
☐	Dental Hygenist
☐	Other (please specify below)

Dietetics	
☐	General
☐	Specialisation (please indicate below)

Speech Pathology	
☐	General
☐	Specialisation (please indicate below)

Physiotherapy	
☐	General
☐	Area of Clinical Interest (if applicable) (please indicate below)

Psychology	
☐	General
☐	Specialisation (area of endorsement - please indicate below)

Other Profession	
☐	
☐	
☐	
☐	

Please complete:	
Clinical Privileging Period sought: (Please tick)	☐ Maximum 3-year period requested ☐ Other from ______________ to ______________ *(insert date)* *(insert date)*

3. Proposed Supervision Arrangements

Please detail your proposed supervision arrangements whilst undertaking clinical services within the Griffith Health Clinics

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4. Scope of Practice

Please detail the range of clinical services which you intend to deliver within the Griffith Health Clinics and any special provisions that need be provided by the Griffith Health Clinics to support the intended clinical service.

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5. Qualifications (non-AHPRA registered professions only)

(Please attach any relevant documentation)

Degree/Fellowship	Conferring Body	Year

6. Details of Membership of Professional Associations

7. Current Appointments

Organisation	Appointments

8. Past Appointments (for five years)

Organisation	Appointments(include date)	Responsibility for patient care Y/N

9. References (for non-Griffith University staff only*)

If you are not a Griffith University staff member please provide the name and email address of at least two professional referees who can attest that your recent practice is consistent with the clinical privileges sought.

We prefer (where possible) that these references are independent and request that at least one referee be external to the clinic in which the clinician is being employed. Where there is a relationship which can lead to a bias, such as a referee and the applicant are in business together as a partnership or are employer/employee, then this relationship must be disclosed by you to the Clinic. The referees provided should be familiar with your current professional capabilities.

Please note that your referees will be contacted and asked to provide a reference. The reference should be in writing.

* Normally Griffith University staff will not need to provide references, however approvers to the CPC process reserve the right to request references if they deem necessary.

Name	Telephone Number and Email Address

10. Registration

Please supply details of your current professional registration:

Registration Body: …………………………………………………………………………………………

Registration Number: …………………………………… Expiration: ……………………………………

Specialty: ……………………………………………………………………………………………………...

Conditions Imposed on Registration (if any): ………………………………………………………………

Please attach a copy of the current Registration Certificate

11. Insurance

Private Practitioners (Griffith staff members working outside of workload) and External Practitioners (non-Griffith employees) are required to carry their own Professional Indemnity and Public Liability insurances. Griffith staff working under an Intra-mural Professional Practice (IPP) arrangement (that is, working within workload) while covered under the University Professional Indemnity and Public Liability Insurances are encouraged to carry their own insurance.

Please note that by submitting this application you consent to a representative from Griffith Health Clinics contacting your defence organisation / insurer to verify that you maintain appropriate indemnity coverage for the privileges sought.

Do you have current Professional Indemnity Insurance? Yes ☐ No ☐

Do you have current Public Liability Insurance? Yes ☐ No ☐

Please provide details and any conditions:

……..

……..

Please attach a copy of your current Certificate of Currency for your Insurance Policies
(a tax invoice is NOT acceptable evidence)

12. Disclosure

a) Have you ever had any restrictions placed on your Professional Registration?

Yes ☐ No ☐

If you answered yes to the above, please provide details (including details of the restriction and what period during which the restrictions apply/applied):

………..

………..

b) Have you previously been refused clinical privileges at another health care facility?

Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the Griffith Health Group may contact the facility.

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………..

c) Have your clinical privileges ever been withdrawn, suspended or not renewed on the basis of clinical competency at another facility?

Yes ☐ No ☐

If you answered yes to the above, please provide name of the facility & rationale for refusal. Please note, a senior executive of the Griffith Health Clinics may contact the facility.

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d) Have there ever been any serious adverse findings made against you which would be relevant to your appointment (for example: breach of insurance / medical laws, professional misconduct, sexual assaults or assault) by the, Health Insurance Commission, a Health Board, a Health Care Complaints Commission/Body, a Coroner, a Court or any other professional disciplinary or similar body?

Yes ☐ No ☐

If you answered yes to the above, please provide details:

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13. Disclosure (continued)

e) Are you currently under investigation for matters of conduct, performance or impairment

Yes ☐ No ☐

If you answered yes to the above, please provide details

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………...

f) Criminal Record Check – Have you been convicted of or pleaded guilty to a criminal offence including a serious sex or violence offence or an offence involving dishonesty or drugs (other than a spent conviction)?

Yes ☐ No ☐

If you answered yes to the above, please provide details:

………...

………...

g) Is there any other information that you should disclose that is relevant to your application?

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14. Representation and Warranty (Acceptance of Terms & Conditions)

The information provided by me to the Griffith Health Group in this application and in connection with this application is accurate and complete and is not misleading or deceiving or likely to mislead or deceive.

I understand that if I have provided misleading or deceptive information or information which is likely to mislead or deceive that Griffith Health Clinics may (in its absolute discretion) consider that I do not have “current fitness” to practice within Griffith Health Clinics.

I agree that I will notify the Head of School in which my clinic resides of any material changes to the information provided by me in connection with this application as soon as possible after the change.

I understand that my appointment as an accredited health professional if granted, will be valid for 3 years or earlier if considered necessary by either party.

I agree, annually, to provide copies of current professional indemnity insurance, registration and other documents as requested.

If appointed, I agree to abide by the Policies and Guidelines of the Clinic.

If appointed, I agree to practice within the Scope of Practice defined by the registering body and specified by the Clinic/School in which I practice.

I confirm that I am competent and qualified to perform any procedures within the specification.

I agree that should any notifiable events occur, I will immediately notify the Head of School.

Applicant Signature: ______________________________ **Date:** ______________________

Witness Name: ________________________________

Witness Signature: _______________________________ **Date:** ______________________

12. Consideration of Clinical Privileging Application

Office Use Only

1. Recommended by relevant Griffith Health Clinic Lead:

Name (Print): ______________________ Signature:______________________________

Date: ____________________________

Comment: (add separate report if desired)

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2. Recommended by Head of School:

Name (Print): ______________________ Signature:______________________________

Date: ____________________________

Comment: (add separate report if desired)

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3. **Recommended by Clinical Privileging Committee**

Signature: ___________________________________ Date:____________

4. Approved by Pro-Vice Chancellor (Health):

Signature: ___________________________________ Date:____________

CHECKLIST

Please ensure that this form is fully completed and that the following documentation (where applicable) is included with this application:

1. Provider/prescriber/registration/radiation or other licensing details where applicable (including registered scope of practice and any limitations to registration awarded by the relevant registration body as applicable);
2. Qualifications (non-AHPRA registered professions only)
3. Curriculum vitae
4. Insurance (including indemnity and medical malpractice insurance where applicable);
5. Other requirements as specified by the relevant Clinic Director:
    - Immunisation status
    - Currency of first aid qualification
    - Current criminal record checks including Blue Card where applicable
6. Contact details (including telephone) from at least two professional referees where applicable (non Griffith staff),
7. Further information as requested by the committee.

❖ Please note that incomplete applications will not be considered ❖

Privacy

Griffith University collects, stores and uses personal information only for the purposes of administering your enquiry. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. For further information consult the University's Privacy Plan.