SENTIENS CLINIC

CLINICAL CREDENTIALLING AND PRIVILEGING - Medical

Application Form

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

Please attach to the Form:

1. Curriculum Vitae, including certified copies of all original qualifications
2. Copy(ies) of current Medical Registration
3. Copy of current Professional Indemnity Cover Certificate
4. Copies of relevant Visa Documents if applicable
5. Referee contact details

APPLICANT AND CONTACT DETAILS:

Name:

Previous name (please indicate your previous name if that appears on certificates) **:**

Date of Birth: **Place of Birth:**

Residency Status: (Australian citizen/permanent/temporary resident)

Professional Address:

Private Address:

Phone: (H) (M) (F) (pager)

e-mail address

DEFINE SCOPE OF CLINICAL PRACTICE:
Include all areas of practice. If further space required please attach a separate sheet
Specifics of practice may include – speciality, Psychiatry, Psychotherapy, specific diagnostic criteria, hours of practice.

a) Adult Psychiatry ☐

b) Adolescent Psychiatry ☐

c) Child Psychiatry ☐

d) Old Age Psychiatry ☐

e) Psychotherapy ☐

f) Workers Compensation ☐

g) Forensic ☐

h) Bipolar Disorder ☐

i) Schizophrenia ☐

j) Anxiety Disorder ☐

k) Personality Disorder ☐

l) Anxorexia nervosa ☐

m) Other

____

Declaration

As recommended under the Standard for Credentialing and Defining the Scope of Clinical Practice of the Australian Council for Safety and Quality in Health Care, with respect for the information required for initial and ongoing credentialing of a medical practitioner, Sentiens requires the following declaration BE completed by the 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 of practice (other than for organisational need and/or capability reasons) in any other organisation 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:

All applications are considered by the Credentialing Committee of Sentiens Pty Ltd.

SENTIENS CLINIC

REFEREES

Please provide details of two independent professional referees, preferably at least two in your speciality, who have been in a position to judge your qualifications and experience during the past five years and who have no conflict of interest in providing a reference.

Referee 1:			
Name:			
Position held currently:			
Professional address:			
Phone: (H)	(B)	(M)	(F)
e-mail address:			

Referee 2:			
Name:			
Position held currently:			
Professional address:			
Phone: (H)	(B)	(M)	(F)
e-mail address:			

SENTIENS CLINIC

REGULATORY AND PROFESSIONAL INDEMNITY INFORMATION:

Medical Registration Board: (attach a copy of current registration certificate) **Registration number:** (if registration is temporary, provide details)
College, Fraternity or Affiliations:
Current professional indemnity/medical indemnity cover: **Expiry date of policy:** (attach a copy of current policy)
Provider number: (Please provide details of any restrictions)
Prescriber number:

PLEASE PROVIDE DETAILS OF:

(Please provide all information if any of the below has applied to you)
(A full detailed explanation for each matter is essential)
(Attach a separate sheet if required)

Has there ever been or are there currently any pending claims, settlements or judgements against you?

☐ Yes ☐ No

Has your medical defence organisation ever excluded any specific area of practice, or terminated ore denied coverage?

☐ Yes ☐ No

Have you been the subject of any disciplinary action?

☐ Yes ☐ No

Have you been convicted of a drug or alcohol related offence

☐ Yes ☐ No

Do you have a disability/health impairment that may compromise your ability to perform any cognitive or physical functions related to your specific area of speciality

☐ Yes ☐ No

QUALIFICATIONS

Qualifications	University/Organisation	Year obtained	Date sighted	Employee Signature	Employer Signature

Please provide copies of qualifications obtained

SENTIENS USE ONLY		
Applicants Name:		
Area of work: (i.e. G.P. service, Clinic 1st Floor)		

1. Contact details provided
2. Qualifications
3. Training and Experience
4. Continuing Education
5. Registration Current
6. Medical Indemnity currency
7. Provider Number
8. Referees
9. Existing Contract checked and relevant documentation available
10. Declaration signed
11. Other comments

Application Details checked by (Name)		
Signature:		Date:
Application	approved	rejected
Letter sent to Applicant	Yes	copy attached