



# COLIN STREET DAY SURGERY

51 Colin Street  
WEST PERTH WA 6005  
ABN: 94 078 443 455

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reception@clds.com.au

## APPLICATION FOR ACCREDITATION FORM

### PERSONAL INFORMATION

Surname:..... Given Names: .....  
Date of Birth:..... Mobile: .....  
Practice Address: .....  
Phone: ..... Fax: .....  
E-mail address: ..... Home address: .....  
..... Phone: .....

### QUALIFICATIONS

Basic Medical Degree: .....  
Post Graduate Degree: .....  
Other: .....

### ACCREDITATION PRIVILEGES

Clinical privileges are sought in the field(s) of:

<input type="checkbox"/> <b>Anaesthetics</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric	<input type="checkbox"/> <b>Dental</b> <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Peridontics	<input type="checkbox"/> <b>ENT</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric
<input type="checkbox"/> <b>Adult Surgery</b> <input type="checkbox"/> <b>Paediatric Surgery</b> <input type="checkbox"/> <b>Facio-maxillary Surgery</b> <input type="checkbox"/> <b>Ophthalmics</b>	<input type="checkbox"/> <b>Plastics / Reconstructive</b> <input type="checkbox"/> Cosmetic <input type="checkbox"/> Hand	<input type="checkbox"/> <b>Minor Orthopaedics</b> <input type="checkbox"/> Adult <input type="checkbox"/> Paediatric

Other: .....

### DETAILS OF CURRENT PROFESSIONAL APPOINTMENTS:

Current / past: .....  
Current / past: .....  
Current / past; .....  
Current / past: .....

### MEMBERSHIP OF COLLEGES AND / OR RELEVANT ASSOCIATIONS

1. ....  
2. ....  
3. ....  
4. ....

<b>QUALITY ASSURANCE</b>	<b>YES</b>	<b>NO</b>
Have your clinical privileges been suspended / revoked / limited at any other facility?		
Please provide details:		
Are you currently, or have you ever been involved in civil or criminal proceedings?		
Provide details:		
<b>INFECTION CONTROL</b> (PLEASE CIRCLE)		
Are you known to have any conditions likely to result in transmission of infection to others?	<b>YES</b>	<b>NO</b>
.....		
<b>REFEREES</b> ( Name & address of 2 referees that will support your application. Referees must have worked with you in the scope of clinical practice you have nominated on this form) PLEASE PRINT		
1.		
2.		
<b>ESSENTIAL DOCUMENTATION TO BE PROVIDED</b>		
<input type="checkbox"/> Copy of Medical / Dental Board Registration must accompany application		
<input type="checkbox"/> Copy of current Curriculum Vitae		
<input type="checkbox"/> Copy of current Medical Defence Insurance Policy OR		
<input type="checkbox"/> Letter has been provided to MDA authorising Colin Street Day Surgery to obtain a current copy of the policy		
<b>AUTHORITY</b>		
I hereby apply for accreditation at Colin Street Day Surgery with the clinical privileges I have specified		
<b>In making this application I acknowledge and agree to:</b>		
Abide by the By-Laws of Colin Street Day Surgery and its policies & procedures		
Abide by Colin Street Day Surgery Risk Management Policy		
Provide annual proof of current professional indemnity insurance/registration		
Colin Street Day Surgery's executives and the Medical Advisory Committee may seek information about my past experience, clinical performance and current fitness		
Signature:.....Date: ...../...../.....		
<b>Please ensure essential documentation accompanies this application</b>		

**Office Use only:**

Date application received: ..... Date presented to Credentialing Chairman .....

Temporary accreditation provided by: ..... Date: .....

Date presented to Credentialing Committee: .....

Accreditation granted: \_\_\_\_/\_\_\_\_/\_\_\_\_/.

All essential documentation presented.....