



COLIN STREET DAY SURGERY

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

P: 08 9321 4256
F: 08 9321 1769
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"/> Anaesthetics
<input type="checkbox"/> Adult
<input type="checkbox"/> Paediatric | <input type="checkbox"/> Dental
<input type="checkbox"/> Oral Surgery
<input type="checkbox"/> Peridontics | <input type="checkbox"/> ENT
<input type="checkbox"/> Adult
<input type="checkbox"/> Paediatric |
| <input type="checkbox"/> Adult Surgery
<input type="checkbox"/> Paediatric Surgery
<input type="checkbox"/> Facio-maxillary Surgery
<input type="checkbox"/> Ophthalmics | <input type="checkbox"/> Plastics / Reconstructive
<input type="checkbox"/> Cosmetic
<input type="checkbox"/> Hand | <input type="checkbox"/> Minor Orthopaedics
<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

-
-
-
-

QUALITY ASSURANCE	YES	NO
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:		
INFECTION CONTROL (PLEASE CIRCLE)		
Are you known to have any conditions likely to result in transmission of infection to others?	YES	NO
.....		
REFEREES (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.		
ESSENTIAL DOCUMENTATION TO BE PROVIDED		
<input type="checkbox"/> Copy of Medical / Dental Board Registration must accompany application		
<input type="checkbox"/> Copy of Laser Certificate provided (if applicable)		
<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		
<input type="checkbox"/> Copy of Working with Children Criminal Record Evaluation Card – this is mandatory if working with children 18 years or under. It is not a police clearance (application is obtained from Post Office, category 13. Application must be done in person, proof of identity required)		
AUTHORITY		
I hereby apply for accreditation at Colin Street Day Surgery with the clinical privileges I have specified		
In making this application I acknowledge and agree to:		
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		
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:/...../.....		
Please ensure essential documentation accompanies this application		

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 present;