



## COLIN STREET DAY SURGERY

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

P: 08 9321 4256  
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reception@csds.com.au

### APPLICATION FOR ACCREDITATION REAPPOINTMENT

I wish to apply for reappointment of my accreditation privileges at Colin Street Day Surgery. I here by state that there are no changes to the information supplied to CSDS since I last applied and I have received a copy of the Colin Street Day Surgery By Laws and agree to abide by them.

I have provided Colin Street Day Surgery with essential documentation as required by the National Credentialing Standard and according to my nominated scope of clinical practice.

Signed: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_.

Print Name: \_\_\_\_\_

**If you have not submitted essential documentation, or if there have been any changes to the information supplied since you last applied, please complete the following application.**

### ACCREDITATION RE-APPOINTMENT 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"/> Dental                    | <input type="checkbox"/> ENT          |
| <input type="checkbox"/> Adult              | <input type="checkbox"/> Oral Surgery              | <input type="checkbox"/> Adult        |
| <input type="checkbox"/> Paediatric         | <input type="checkbox"/> Periodontics              | <input type="checkbox"/> Paediatric   |
| <input type="checkbox"/> Adult Surgery      | <input type="checkbox"/> Plastics / Reconstructive | <input type="checkbox"/> Orthopaedics |
| <input type="checkbox"/> Paediatric Surgery | <input type="checkbox"/> Cosmetic                  | <input type="checkbox"/> Adult        |

<input type="checkbox"/> <b>Facio-maxillary Surgery</b> <input type="checkbox"/> <b>Ophthalmics</b>	<input type="checkbox"/> <b>Hand</b>	<input type="checkbox"/> <b>Paediatric</b> <b>Other:</b>
<b>DETAILS OF CURRENT PROFESSIONAL APPOINTMENTS:</b>		
Current / past: .....		
Current / past: .....		
Current / past; .....		
Current / past: .....		
<b>MEMBERSHIP OF COLLEGES AND / OR RELEVANT ASSOCIATIONS</b>		
1. ....		
2. ....		
3. ....		
4. ....		

<b>QUALITY ASSURANCE</b>	<b>YES</b>	<b>NO</b>
<b>Are you currently or have you ever had your clinical privileges been suspended / revoked / limited at any other facility?</b>		

**Please provide details:**

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<b>Are you currently or have you ever been involved in civil or criminal proceedings?</b>		
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**Provide details:**

<b>INFECTION CONTROL</b>	(PLEASE CIRCLE)	
<b>Are you known to have any conditions likely to result in transmission of infection to others?</b>	<b>YES</b>	<b>NO</b>

.....

<b>REFEREES ( Name &amp; 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</b>
1. ....
2. ....

<b>ESSENTIAL DOCUMENTATION TO BE PROVIDED</b>
<input type="checkbox"/> <b>Copy of Medical / Dental Board Registration must accompany application</b>
<input type="checkbox"/> <b>Copy of Laser Certificate ( if applicable)</b>
<input type="checkbox"/> <b>Current Curriculum Vitae</b>
<input type="checkbox"/> <b>Copy of current Medical Defence Insurance Policy OR</b>
<input type="checkbox"/> <b>Letter has been provided to MDA authorising Colin Street Day Surgery to obtain a current copy of the policy</b>
<input type="checkbox"/> <b>Copy of your Working with Children Criminal History Evaluation Card if working with children 18 years and under. This is not a police clearance</b> (application is obtained from Post Office, category 13. Application must be done in person, proof of identity required )

<b>AUTHORITY</b>
<input type="checkbox"/> 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>
<b>Abide by the By-Laws of Colin Street Day Surgery and its polices and procedures</b>
<b>Abide by Colin Street Day Surgery Risk Management Policy</b>
<b>Provide annual proof of current professional indemnity insurance</b>
<b>Colin Street Day Surgery's executives and the Medical Advisory Committee may seek information about my past experience, clinical performance and current fitness</b>
Signature:.....Date: ...../...../.....
<b>Please ensure essential documentation accompanies this application</b>

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**Office Use only:**

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

Date presented to Credentialing Committee: .....

Re-appointment granted: \_\_\_\_/\_\_\_\_/\_\_\_\_/.

All essential documentation present; .....