



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

**DETAILS OF CURRENT PROFESSIONAL APPOINTMENTS:**

Current / past: .....

Current / past: .....

Current / past; .....

Current / past: .....

**MEMBERSHIP OF COLLEGES AND / OR RELEVANT ASSOCIATIONS**

1. ....

2. ....

3. ....

4. ....

**QUALITY ASSURANCE**

YES

NO

Are you currently or have you ever had 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** Copy of Medical / Dental Board Registration must accompany application Current Curriculum Vitae Copy of current Medical Defence Insurance Policy OR Letter has been provided to MDA authorising Colin Street Day Surgery to obtain a current copy of the policy if not provided or apart of registration**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 polices and 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 .....

Date presented to Credentialing Committee: .....

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

All essential documentation present; .....