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@csds.com.au

APPLICATION FOR ACCREDITATION FORM

PERSONAL INFORMATION			
Surname:		**Given Names:**	
DOB:	**M:**	**P:**	**Email:**
Practice Address:			
Phone Number:		**F:**	**Email:**
Home Address:			
Provider Number:			

QUALIFICATIONS
Basic Medical Degree:
Post Graduate Degree:
Other:

ACCREDITATION PRIVILEGES

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

☐ **Anaesthetics** ☐ Adult ☐ Paediatric ☐ < 2 yrs old ☐ > 2 yrs old	☐ **Dental** ☐ Oral Surgery ☐ Peridontics	☐ **ENT** ☐ Adult ☐ Paediatric
☐ **Adult Surgery** ☐ **Paediatric Surgery** ☐ **Facio-maxillary Surgery**	☐ **Plastics / Reconstructive** ☐ Cosmetic ☐ Hand	☐ **Minor Orthopaedics** ☐ Adult

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.

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
☐ Copy of Medical / Dental Board Registration must accompany application
☐ Copy of 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

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, Code of Conduct, Policies & Procedures
Abide by CSDS's Risk Management Programme and The National Safety & Quality Service Standards and all that this entails as a Credentialed Medical Officer at CSDS.
Provide annual proof of current professional indemnity insurance/registration
Colin Street Day Surgery's Executives and Credentialing Committee may seek information about your 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 presented……………………………………………………………………………….