Queensland Government

Queensland Health

Application for Scope of Clinical Practice

NB: Information included on this application is for **Apunipima Cape York Health Council Medical Practitioners** providing general practice services in Torres and Cape Hospital and Health Service facilities. The information requested on this application form is additional to information contained within your current Curriculum Vitae (CV).

Type of Application:

☐ New Application ☐ Renewal Application ☐ Additional / Changed SoCP Application

Hospital & Health Service where SoCP is requested:

Torres and Cape Hospital and Health Service for: apunipima CAPE YORK HEALTH COUNCIL

Scope of Clinical Practice Requested

General Practice

☐ **Specialist General Practice** ☐ **Non-Specialist General Practice** ☐ **Supervised General Practice**

Unless otherwise specified, routine scope of clinical practice in General Practice includes emergency care, all primary care areas including geriatrics, paediatrics, palliative care, antenatal care, psychiatry, internal medicine, closed orthopaedics, care of health service inpatients and patients in QH Residential Aged Care Facilities, and outpatient care.

Specify any exclusions: .....

Personal Details

Last name:			
First name:		**Middle name:**	
Previous name:		**Preferred Name:**	

(Please include your previous name if that appears on certificates. Include evidence of reason of name change)

Date of birth:		**Gender:**	☐ Female ☐ Male

Contact Details

Home address: Preferred address for correspondence	**Practice address:** Preferred address for correspondence

Phone:	**Mobile:**	**Fax:**
Email (1):		
Email (2):		

AHPRA Registration Details

Registration Number:

Registration Type/s: General Specialist (please state below) Other (please state below)

Specialty/Other registration type:

Professional Indemnity Insurance (please attach copy of Certificate of Currency)

Current professional indemnity insurance? Yes No

Insurance agency	Category of coverage	Expiry date

Qualifications

Qualification	University/College/Organisation	Year Obtained

Please refer to CV for supporting information

Training Program Details

If you are on an approved College training program, please provide details and include a copy of your training agreement with your application:

College/training pathway:

Training provider:

Commencement date:

Planned completion date:

Name of principal supervisor:

Current Clinical Appointment(s)

List appointments and current SoCP that would continue concurrently at other public and private health care facilities, including period of time.

Appointment	Scope of Clinical Practice	HHS / Organisation

Please refer to CV for supporting information

Continuing Education and Quality Activities

It is a requirement of the Medical and Dental Boards of Australia that all practitioners undertake Continuing Medical Education (CME) / Continuing Professional Development (CPD) activities as a condition of registration. You must provide evidence of participation in CPD programs and activities consistent with the Board approved standards and which is relevant to the SoCP requested.

NB: For applicants who have obtained a fellowship within the past 12 months, the fellowship certificate will be considered to be sufficient evidence of CPD.

Are you undertaking the requirements for continuing education, re-certification, etc required by the Medical / Dental Boards of Australia?

Yes – supporting documentation must be attached to this application ▼

College / Organisation / Program	Currently enrolled	Date completed *(if applicable)*

No – please explain ▼

Clinical Audit / Peer Review Activities

Do you subject your clinical work to quality activity mechanisms including clinical audit, peer review etc?

Yes – please describe ▼

Organisation	Type of activity	Frequency	Reports attached
e.g. M&M Meeting	*e.g. Quality and Clinical Peer Review*	*e.g. Monthly*	

No – please explain ▼

References

Please nominate a **minimum of two** professional peer referees, with no conflict of interest, who can attest to your clinical skills and professional performance **within the past 12 months** in the areas for which you have applied for SoCP.

Referee 1 *Designation: Current Line Manager / Professional Peer*	**Name:**	
	Current position:	
	Address:	
	Phone (work):	**Mobile:**
	Email:	
Referee 2	**Name:**	
	Current position:	
	Address:	
	Phone (work):	**Mobile:**
	Email:	
Referee 3	**Name:**	
	Current position:	
	Address:	
	Phone (work):	**Mobile:**
	Email:	

Applicant's Declaration and Authorisation

I, _____ make the following declarations and authorisations.

I will ensure that my professional registration with AHPRA remains current, and acknowledge that failure to do so will lead to suspension of employment and SoCP until rectified.

I will actively participate in Continuing Professional Development (CPD) relevant to the SoCP to which I have applied.

I understand that, in line with the National Standards, basic details of my credentialing and SoCP status will be accessible to relevant departmental and Hospital and Health Service including staff in relevant patient care areas. In applying for SoCP I agree to abide by the:

- **Code of Conduct for the Queensland Public Service** https://www.qld.gov.au/gov/code-conduct-queensland-public-service
- **QH Health Service Directives** https://www.health.qld.gov.au/directives/html/a.asp
- **Department of Health Policies and Regulations** http://www.health.qld.gov.au/qhpolicy/html/index-c.asp • **Hospital and Health Service Policies**
- **Terms and conditions which are attached to my SoCP**

Please respond to each of the questions below by ticking the appropriate box.	**Yes**	**No**
1. Have you ever had an adverse finding/s made against you by a medical/dental registration authority or any other professional, disciplinary or similar bodies, including outside Australia?		
2. Have you ever had conditions or undertakings attached to your registration or had your registration suspended or cancelled by a medical/dental registration authority or similar body, including overseas?		
3. Are you currently under investigation by a medical registration authority, other regulatory authority or health facility in Australia or overseas?		
4. Has your right to practice and/or scope of clinical practice ever been denied, restricted, suspended, terminated or otherwise modified by any health care organisation, health facility, learned college or other official body, including in Australia or overseas?		
5. Has a medical defence insurer of which you have been a member ever applied conditions or refused to renew your cover or membership in Australia or overseas?		
6. Do you have any physical or other medical conditions, including substance abuse, which may limit your ability to exercise the scope of clinical practice for which you have applied?		
7. Do you have any disclosable criminal convictions i.e. convictions as an adult that form part of your criminal history and which have not been rehabilitated under the *Criminal Law (Rehabilitation of Offenders) Act 1986*? If you are unsure about the status of any criminal convictions which you have you may wish to seek legal advice in responding to this question.		

If you responded 'Yes' to any of the above questions, please attach a statement with details, dates and include any relevant documentation.

Details:

I undertake to immediately notify a medical administrator (e.g. EDMS, DMS, DDMS, Clinical Director, Department Head or Medical Manager), Director of Oral Health and the Chair of the Credentialing and SoCP Committee:

1. If I become aware that I have developed a condition which would affect my ability to safely provide care to my patients.
2. Of any changes to my Australian Health Practitioner Regulation Agency (AHPRA) registration.
3. Of any current or new undertakings given or conditions, endorsements, suspensions, reprimands or notations imposed on my registration by AHPRA.
4. If I cease engagement with a Hospital and Health Service/Department of Health division or cease private practice at a Queensland public facility or service.
5. If I experience a restriction, withdrawal or alteration of SoCP at another health care facility or service, whether public or private.
6. Of my annual membership details for personal medical indemnity insurance (if applicable).
7. When any other changes occur to my clinical circumstances that may impact on my granted SoCP.
8. If my contact details (i.e. home/business/email/phone details) change.
9. In accordance with my obligations under the *Public Service Act 2008 QLD* and the Employees to Notify Supervisor if Charged with or Convicted of an Indictable Offence Human Resources Policy E4 (QH-POL-127), employees are to notify supervisor if charged with or convicted of an indictable offense.

I authorise Queensland Health and its officers and/or agencies to:

- Obtain information from the Registration Body, Indemnity Insurance Organisation, Specialist College/s or Societies to which I am associated as nominated in this application, regarding the currency of my registration and/or membership of that body or organisation and regarding any other matter relevant to my application and ongoing SoCP.
- Verify details of this application with relevant individuals, external organisations, previous employer/s and to seek confidential references from nominated referees.

I consent to information regarding my credentialing and SoCP being disclosed by the Department of Health and Hospital and Health Services in the following circumstances:

- for my credentialing and SoCP details to be published in a register on the Queensland Health Electronic Publishing Service (QHEPS)
- for my credentialing and SocP information to be disclosed between differing Hospital and Health Services and the Department of Health for a purpose associated with the approval, amendment or refusal of my credentials and SoCP, including, for example, as part of the mutual recognition process of my credentials and SoCP.

I declare that the facts and my response to this Application are accurate at time of application.

I fully understand that providing false information or documents may result in my SoCP not being granted, and may further result in my being subject to criminal charges and/or disciplinary action.

Print applicant name:	**Print witness name:**
Applicant signature:	**Witness signature:**
Date:	**Date:**

NB: Electronic/digitial signatures are not accepted. Print, sign and return the form with the full application.

Application Document Checklist	New	Renewal	Additional/Change
Current CV			
Current CME/CPD evidence			(relevant to new SoCP requested)
Base degree and specialist qualifications/Fellowship		(new qualifications only)	(relevant to new SoCP requested)
Two referee reports provided			
Professional Indemnity – certificate of currency	N/A	N/A	N/A
Photo identification		N/A	N/A