

# RANDWICK DAY SURGERY APPLICATION FOR CLINICAL PRIVILEGES

I, \_\_\_\_\_  
(Full given names and surname in block letters)

Residential Address \_\_\_\_\_  
\_\_\_\_\_ Tel: \_\_\_\_\_ Mob: \_\_\_\_\_

Practice Address \_\_\_\_\_  
\_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Address for correspondence/reports (Please circle)    HOME                  PRACTICE

Date of Birth \_\_\_\_\_

Provider Number \_\_\_\_\_

**PROFESSIONAL DATA:**

Initial Qualifications:	Degree/Diploma	Issuing Body	Year
_____			

Additional Qualifications \_\_\_\_\_  
\_\_\_\_\_

**NEW APPLICANTS ONLY**

**Privileges Required:**

(a) General Dental    Specialist Dental                  Oral Surgery                  Anaesthetics

Please attach Letters from at least two other hospitals where you have clinical privileges

**or**

Provide the name and contact details of an RDS approved practitioner or a professional colleague as a referee

**or**

The name of the Operating Suite NUM at two hospitals where you currently work.

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**DECLARATION**

**I hereby declare that I have been provided with a copy of the RDS Conditions of Credentialing and agree to abide by all of the terms and conditions therein.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return application form with copies of your current registration and indemnity insurance**